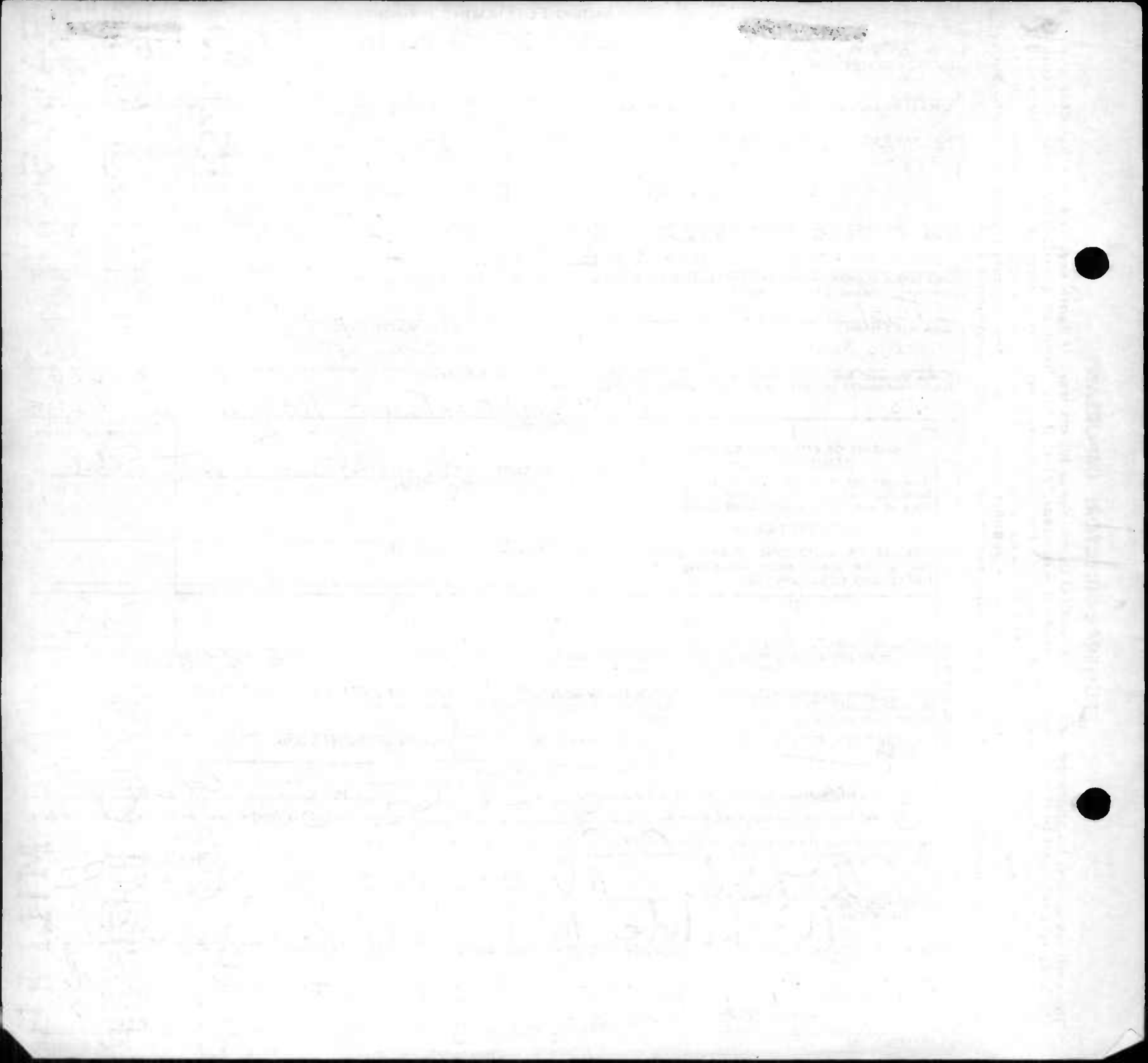


FUNERAL DIRECTOR: IMPORTANT

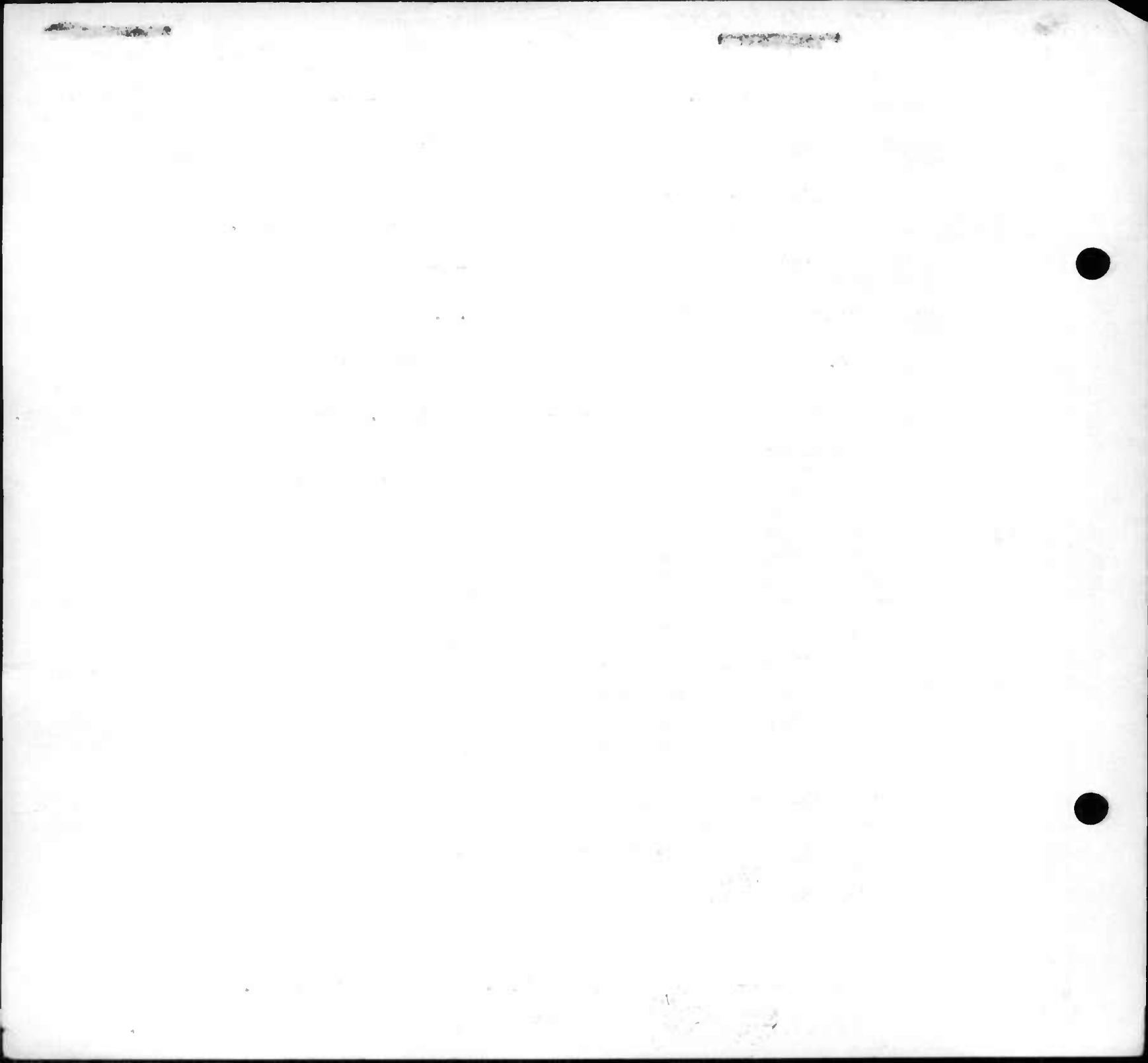
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										
BIRTH NO. 72-06001		REG. NO. 72-06001								
1. NAME OF DECEASED (Type or Print) ALLEN, MAXIE L.					2. DATE AND HOUR OF DEATH 6/25/72 10 15 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 808					
					C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER 1616 E. Chase Street					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/06/05	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Roxboro, N.C.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME George Allen					14. MOTHER'S MAIDEN NAME Eleanor Brown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No			16. SOCIAL SECURITY NO. 213-07-6742		17. INFORMANT HORTENSE NELSON			ADDRESS 1616 E. Chase		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarct					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5da					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: AS HCU D					
					(B) DUE TO, OR AS A CONSEQUENCE OF:					
					(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					542					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/19/72 to 6/25/72 that (I) (we) last saw the deceased alive on 6/25/72 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE W. Rohde MD					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6/25/72		
23C. PHYSICIAN'S NAME (Type) W. Rohde MD					23D. ADDRESS 601 N Broadway Md					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6/29/72		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. PK.		24D. LOCATION (City, town, or county) (State) Arbutus, Md.				
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1972			25B. NAME OF REGISTRAR DEANE J. ...			25C. FUNERAL DIRECTOR Milton E. Erickson			ADDRESS 1129 N. Caroline St	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

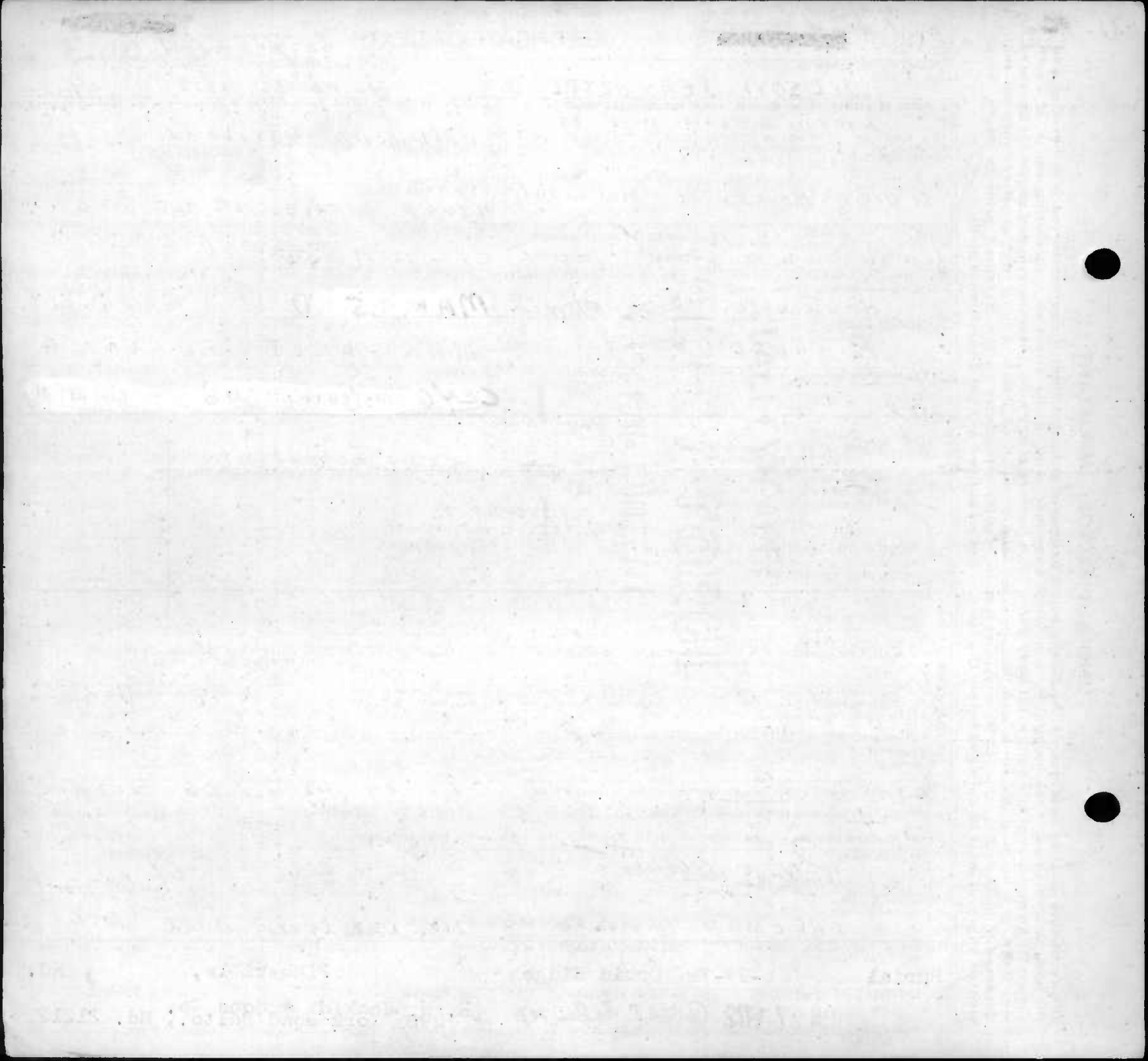
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
Alfred N. Norman		6-26-72 3:50 A. M.		39 Provident Hosptial	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN		6. INSIDE CITY LIMITS?	
A. STATE Maryland		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
C. CITY OR TOWN		D. INSIDE CITY LIMITS?		E. STREET AND NUMBER	
Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		3202 Brightwood Ave.	
7. SEX	8. RACE	9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	10. DATE OF BIRTH	11. AGE (In years last birthday)	12. If Under 1 Yr. Months Days
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-3-12	60	13. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Steelworker		Bethlehem Steel		N.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
George A. Norman		Roberta Lester		Yes WWII	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
240-18-2690		Bessie M. Norman		3202 Brightwood Ave.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		3 hrs 50 min	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Acute Myocardial Infarction			
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerotic Cardiovascular disease		10 yrs +	
		DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Diabetes mellitus		18 yrs +	
II		Arteriolosclerosis		unclear	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2-3-19-72 to 6-9-19-72 that (I) (we) last saw the deceased alive on 6-9-19-72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
John T. Chissell		6-27-72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
John T. Chissell MD		940 W. North Ave Baltimore Md 21217			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6-29-72		Md National Mem. Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 27 1972		Robert E. Fisher, MD		Wm C March	
				ADDRESS	
				928 E North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.
72-06003		72-06003		72-06003
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
WILSON, JEANNETTE B.		June 26 1972 9 am.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Baltimore, Maryland 2711		
FULL NAME OF HOSPITAL OR INSTITUTION +4 Union Memorial Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 4300 N. CHARLES ST. APT. 106				
5. SEX female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-22-17	9. AGE (In years last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA American				
13. FATHER'S NAME Richard Bond		14. MOTHER'S MAIDEN NAME MARGARET FURLONG		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT CLYDE A. WILSON
				ADDRESS (SAME)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 183.0 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF: (B) <i>ovarian carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 06-24-1972 to 06-26-1972, that (I) (we) last saw the deceased alive on 06-26-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ruth S. McQuay		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/26/72
23C. PHYSICIAN'S NAME (Type) FREEMAN, Norman M.D.		23D. ADDRESS 210 - North 27th St. Balt. M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-29-72	24C. NAME OF CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville, Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto.; Md. 21212



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 72-06004		2. DATE AND HOUR OF DEATH 6/23/72 4:45 P. M.	
1. NAME OF DECEASED (Type or Print) RACHEL EVANS		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2758	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		C. CITY OR TOWN BALTO, MD D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hosp		E. STREET AND NUMBER 1612 Sherwood Ave	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		9. AGE (In years last birthday) 88	
10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME THOMAS O. EVANS		12. CITIZEN OF WHAT COUNTRY? U.S.A	
14. MOTHER'S MAIDEN NAME BETSY WILLIAMS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 187-03-3325		17. INFORMANT MRS. THELMA E. PHILLIPS (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 6/15/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/21/72 to 6/23/72 and that (I) (we) last saw the deceased alive on 6/23/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William R. Davidson Jr. M.D.		23B. DATE SIGNED 6/23/72	
23C. PHYSICIAN'S NAME (Type) William R. Davidson Jr. M.D.		23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-72	
24C. NAME OF CEMETERY OR CREMATORY Denison		24D. LOCATION (City, town, or county) (State) Swoyersville, Luzerne Co., Pa.	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1972		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS Balto., Md. 21212	

the / Evans

88 88

NAME: MARKER OWN NAME

PETER WILKINS

THOMAS C. EVANS

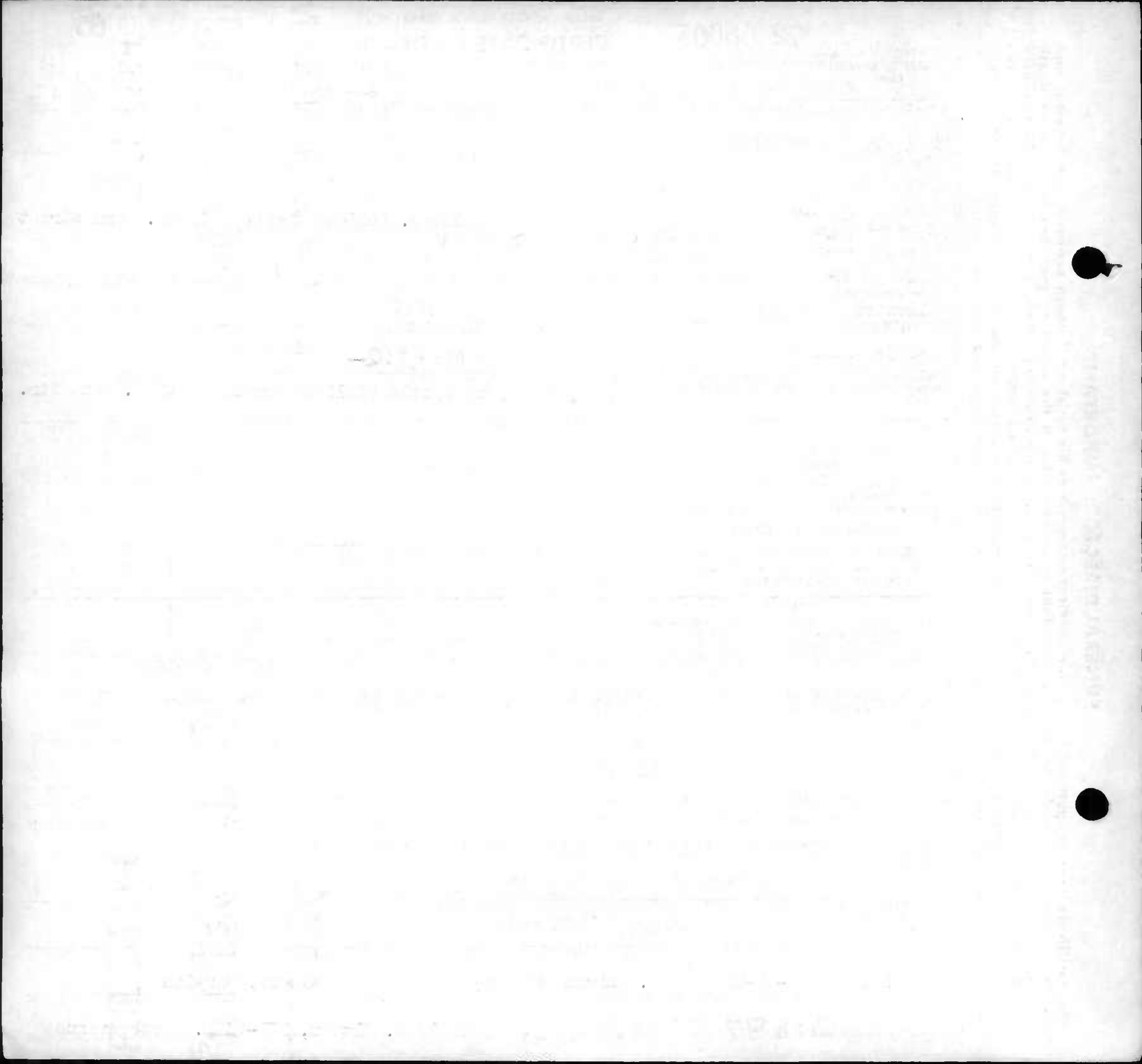
(NAME) FIRST NAME & PHONE

1-1-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06005	
BIRTH NO. 72 06005				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type as Print) WILLIAMS- LATHAN			2. DATE AND HOUR OF DEATH 6-26-72 8 ¹⁰ A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH Home and Hospital 100 N Broadway			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE M D. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1741 N. Bond Street		
5. SEX Male	6. RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-47	9. AGE (In years last birthday) 24	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator			11. BIRTHPLACE (State or foreign country) N.C.		
13. FATHER'S NAME Leslie Williams			14. MOTHER'S MAIDEN NAME Williams MYRTLE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 26-40-5040		
17. INFORMANT Mrs Myrtle Williams Jenkins 1741 N. Bond Str.			18. CAUSE OF DEATH chronic Renal failure		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Nephrotic Syndrome (B) Renal failure DUE TO, OR AS A CONSEQUENCE OF: (C) ?		
19. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 6-13-72 19 to 6-26-72 19 that (I) (we) last saw the deceased alive on 6-11-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr Sajad			23B. DATE SIGNED 6-26-72		
23C. PHYSICIAN'S NAME (Type) MOHAMMAD REZA MOHSENI S AGADI			23D. ADDRESS 100 N Broadway		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-72		24C. NAME OF CEMETERY or CREMATORY MT. Auburn Cemetery	
24D. LOCATION Baltimore, Maryland		24E. CITY, TOWN, or COUNTY		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Donald E. Glover, 712-14 E. North Avenue	



M-620

72 06006

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

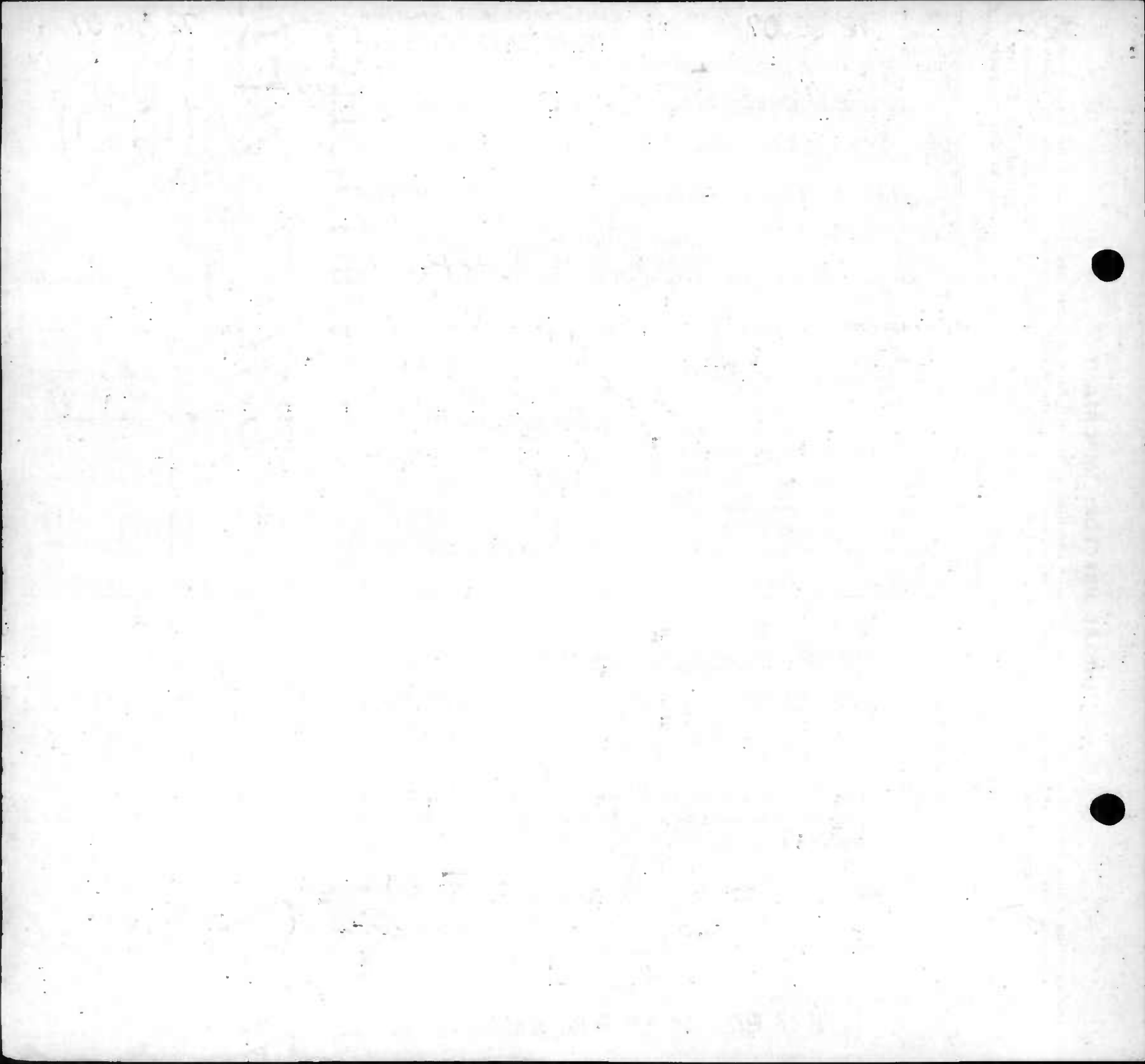
REG. NO. 72 06006

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES H. MORRIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 27, 1972 1:45 A.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1402	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3/14/27		10. AGE (In years last birthday) 45		E. STREET AND NUMBER 1425 Pennsylvania Avenue	
11. BIRTHPLACE (State, foreign country) Black Rock N.C.		12. CITIZEN OF USA		13. FATHER'S NAME John H. Harp	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman Port of Baltimore		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Glady's Morris	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 212-303864		18. INFORMANT Glady's Morris 727 New York Ave	
19. 01119		CAUSE OF DEATH Hemoptysis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary tuberculosis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/27/72					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/30/72		24C. NAME of CEMETERY or CREMATORY MT Auburn	
24D. LOCATION (City, town or county) (State) BALTO MD		25A. DATE REC'D BY HEALTH DEPT. JUN 28 1972			
25B. NAME OF REGISTRAR P. A. E. Fisher, MD		25C. FUNERAL DIRECTOR Marshall P. Hays 638 N. Gilman St			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06007
CERTIFICATE OF DEATH				
BIRTH NO. 72 06007				
1. NAME OF DECEASED (Type or Print) NATHANIEL GUY QUEEN		2. DATE AND HOUR OF DEATH 6/24/72 3:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Hilton Nursing Home 3313 Poplar St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 301 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 34 S. DALLAS ST		
5. SEX M	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JAN 1-1900	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cemetery Sexton		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME OATNEY QUEEN		14. MOTHER'S MAIDEN NAME ALICE JOHNSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-12-3794		17. INFORMANT John C. Stevens ADDRESS Baltimore 1336 N. MOUNTAIN ST
18. 7/12/31 CAUSE OF DEATH ARTERIOSCLEROTIC HEART DISEASE (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 7 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work At Work 21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 2/10/72 19 to 6/24/72 19, that (I) (we) last saw the deceased alive on 6/24/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature] OEGREE		23B. DATE SIGNED 6/24/72		23C. PHYSICIAN'S NAME (Type) HOLLIS SEUNARINE OEGREE
23D. ADDRESS 1801 Greenbury Rd, Balt, Md				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-28-72	24C. NAME OF CEMETERY or CREMATORY Brewer Hill	24D. LOCATION (City, town, or county) (State) ANNAPOLIS A.A. Co Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1972	25B. NAME OF REGISTRAR P. R. E. J. B. R. R.	25C. FUNERAL DIRECTOR C. F. HICKS III	ADDRESS 1922 Forest Drive Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH						REG. NO. <u>72 06008</u>
BIRTH NO. <u>72 06008</u>						
1. NAME OF DECEASED (Type or Print) BENNETT, WILLIAM GEORGE			2. DATE AND HOUR OF DEATH JUNE 25 1972 9:55P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY 2553 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2054 WHISTLER AVENUE 21230			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07 15 80	9. AGE (In years last birthday) 91	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAT BLOCKER	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAT BLOCKER			10B. KIND OF BUSINESS OR INDUSTRY HAT		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Bennett			
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 216 05 1570			17. INFORMANT WIKKENS AVENUE 21229			
18. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY FAILURE ± 1h. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. operation + Marasmus ± 3 days a.s.c.v.d. years.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 18 1972 to JUNE 25 1972 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 25 1972 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.						
23A. SIGNATURE J.J. Mol				23B. DATE SIGNED 06 26 72		
23C. PHYSICIAN'S NAME (Type) J.J. Mol				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-72		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 28 1972				
25B. NAME OF REGISTRAR Robert E. J. [illegible]		25C. FUNERAL DIRECTOR McCully Funeral Home				
ADDRESS 237 Patapsco Avenue Balto., Md 21225						

6/29/72 - Operation 6/21 - Temporary

Pacemaker Inserted

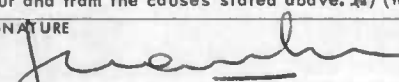
6/22 Repositioning of Pacemaker

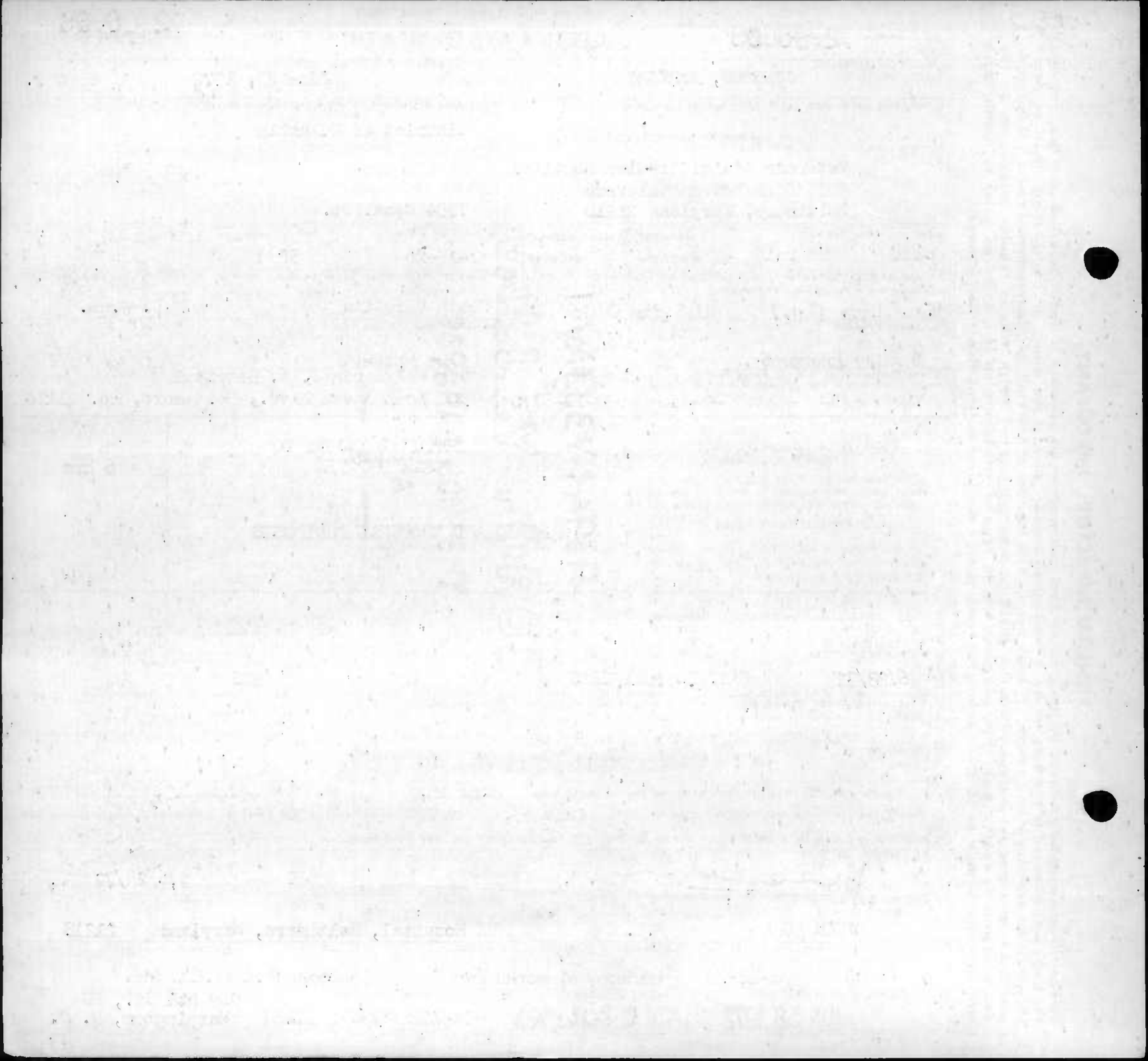
Information from LA Agnes Hosp via phone
+ letter in filed in Bur of
Biostat - American Ref

92

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

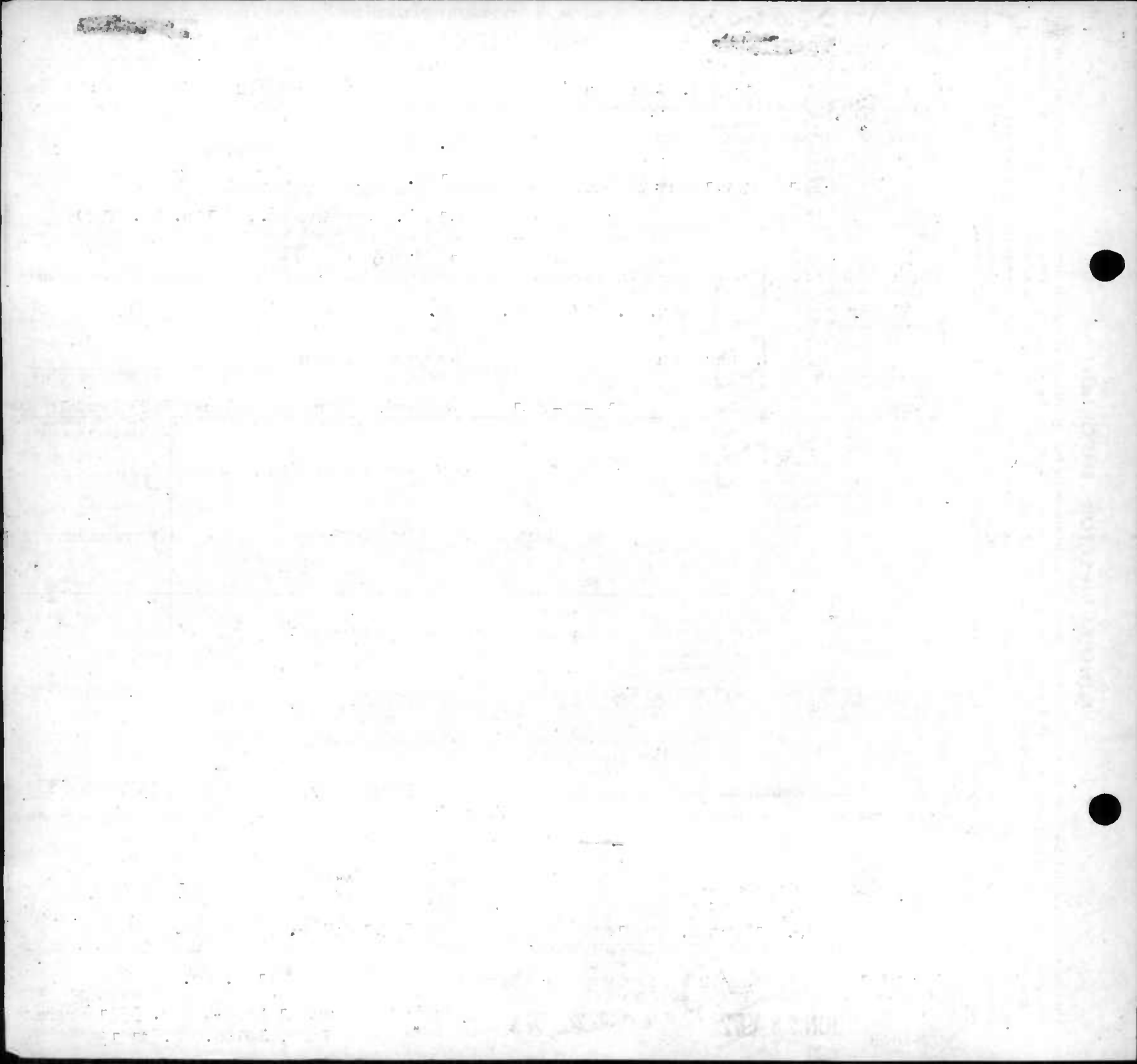
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 Q6009</u>
BIRTH NO. <u>72 Q6009</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>JOHNSON, BERKLEY</u>		2. DATE AND HOUR OF DEATH <u>June 23, 1972</u> <u>8:00 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>District of Columbia</u> B. COUNTY <u>V48</u> C. CITY OR TOWN <u>Washington</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7354 Canal St.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negroid</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-20</u>	9. AGE (In years last birthday) <u>52</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Office (Ret.)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Berkley Johnson Sr.</u>		
14. MOTHER'S MAIDEN NAME <u>Cora Mickel</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>6-41 to 9-2-45</u>		
16. SOCIAL SECURITY NO. <u>579-18-5778</u>		17. INFORMANT <u>Records V. A. Hospital</u> ADDRESS <u>3900 Loch Raven Blvd., Baltimore, Md. 21218</u>		
18. <u>211.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>SURGICAL INJURY TO PORTA HEPATIS</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>GASTRIC AND DUODENAL POLIPOSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
19A. DATE OF OPERATION <u>6/23/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GASTRIC POLIPOSIS</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>II</u> (this hospital) attended the deceased from <u>June 15,</u> 19 <u>72</u> to <u>June 23,</u> 19 <u>72</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>June 23,</u> 19 <u>72</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED <u>6/24/72</u>		23C. PHYSICIAN'S NAME (Type) <u>JUAN LORA</u> M.D.
23D. ADDRESS <u>VA Hospital, Baltimore, Maryland</u> <u>21218</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>6-28-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Harmony Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Landover Pr. Geo. Co. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>TAYLOR FUNERAL HOME</u>
25D. ADDRESS <u>909 6th St., NW</u>		<u>Washington, D. C.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

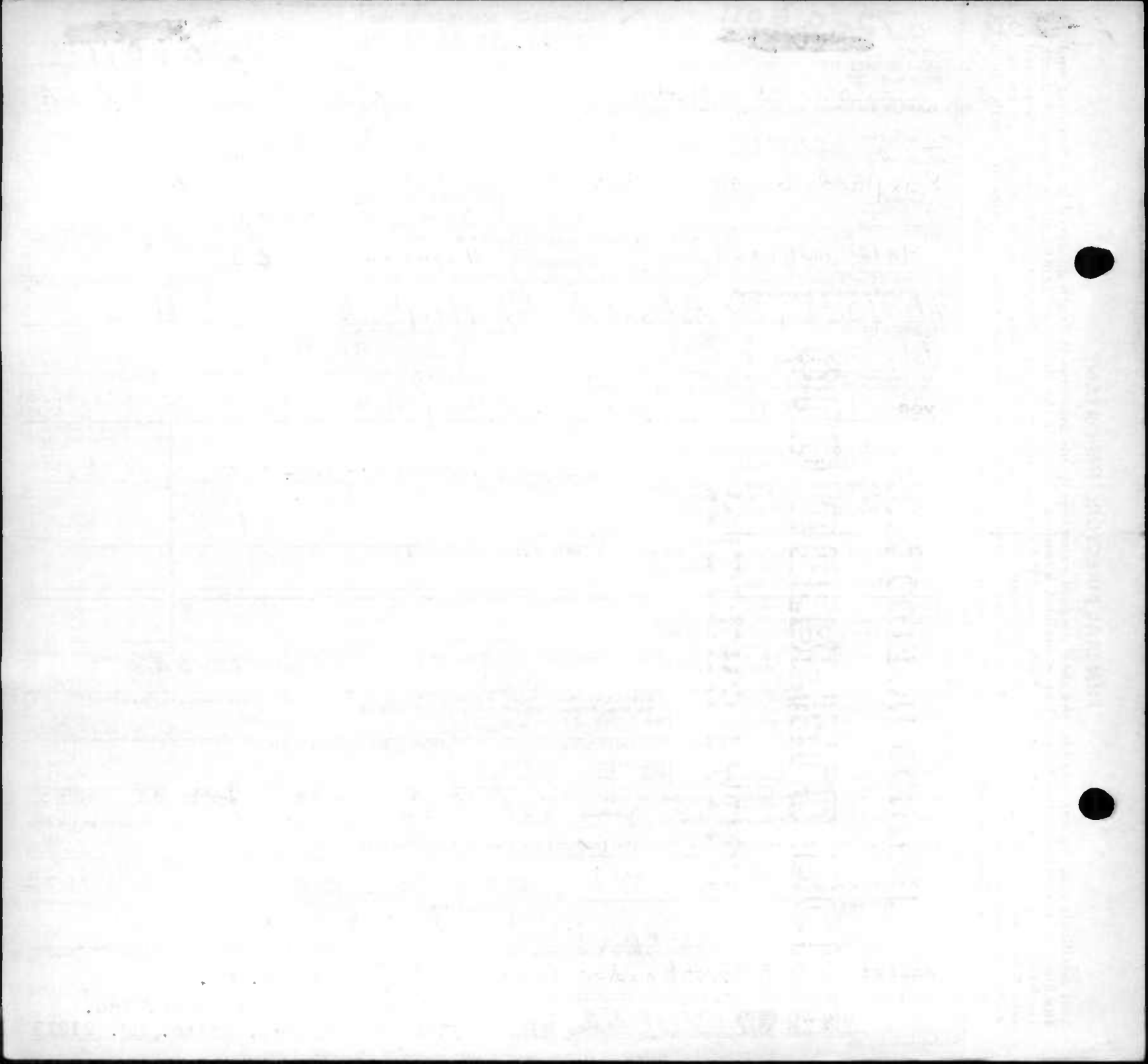
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72-06010	
BIRTH NO. 72-06010				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Adam C. Cunzeman			2. DATE AND HOUR OF DEATH 6/22/72 6:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalescent Home			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 701		
			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2915 E. Monument St., Balto. Md. 21205		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/22/86		9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tinner		10B. KIND OF BUSINESS OR INDUSTRY Robt. G. Fick & Co.	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Adam C. Cunzeman			14. MOTHER'S MAIDEN NAME Margaret Hamann		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 216-05-4701	17. INFORMANT ADDRESS Catherine Cunzeman (niece) 3923 Lyndale Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Arteriosclerotic Heart Disease years DUE TO, OR AS A CONSEQUENCE OF:		
			(B) Grandchild Arteriosclerosis year DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic renal disease; Chronic Brain Syndrome					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/9/1972 to 6/22/1972 , that (I) (we) last saw the deceased alive on 6/17/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 6/24/72	
23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley				23D. ADDRESS 4900 Belair Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/72		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 28 1972			
25B. NAME OF REGISTRAR Robert E. Fick, Jr.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

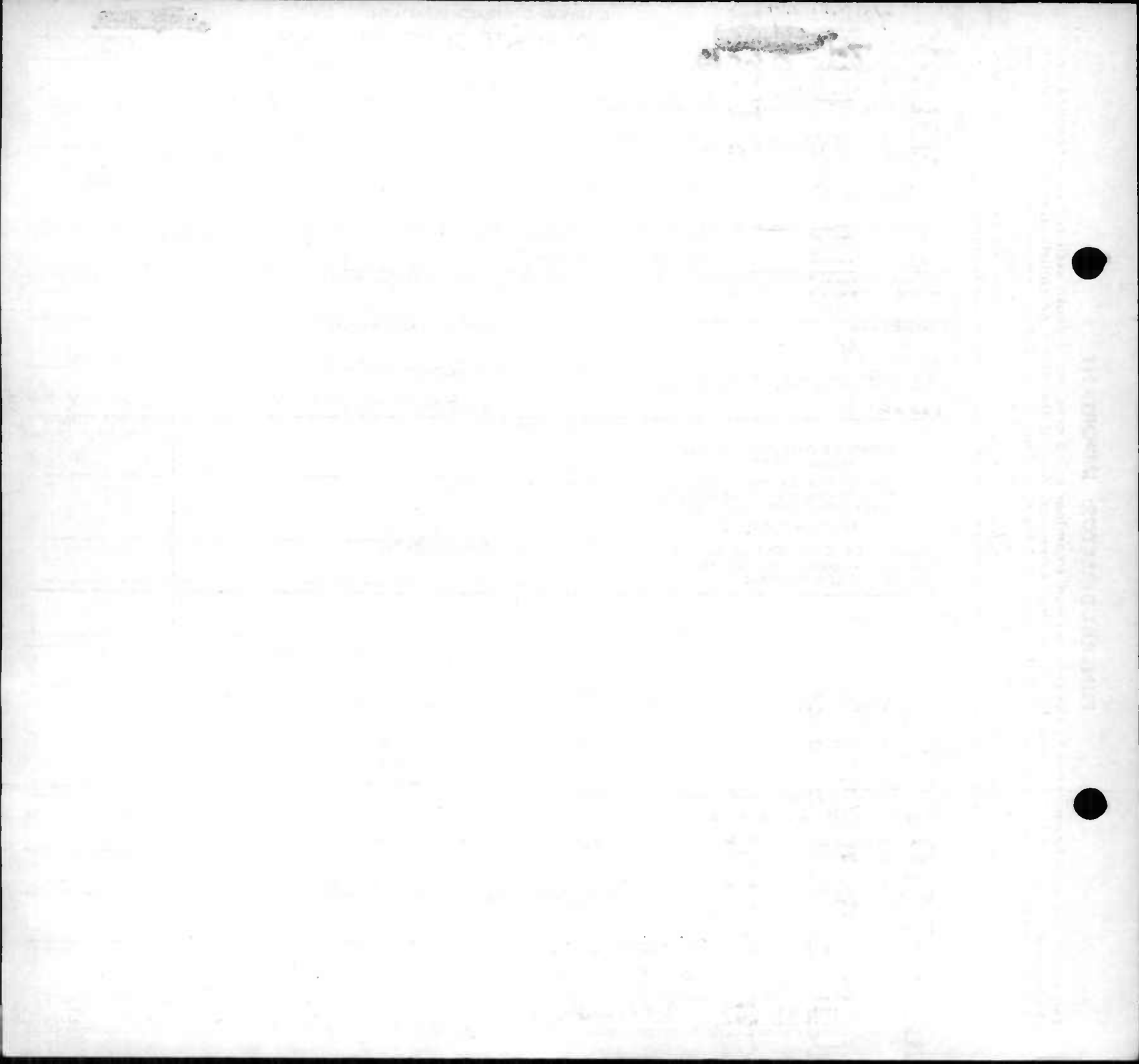
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72-06011</u>
CERTIFICATE OF DEATH				72-06011
BIRTH NO. <u>72-06011</u>		1. NAME OF DECEASED (Type or Print) <u>John L. Helm</u>		
2. DATE AND HOUR OF DEATH <u>6-25-72 10:15 A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital 48</u>		
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>3543 Juneway</u>				
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-10</u>	9. AGE (in years last birthday) <u>62</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>National Brewing Co. saleswoman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>National Brewing Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>John Frederick Helm</u>		
14. MOTHER'S/MAIDEN NAME <u>Ema Phillips</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW II</u>		
16. SOCIAL SECURITY NO. <u>213-10-2071</u>		17. INFORMANT <u>Mary Helm Traynor</u> ADDRESS <u>327 Stratford Rd</u>		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>162.11 I</u> <u>Brachyogenic Ca metastases</u>				<u>11 wks</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>June 12</u> 19 <u>72</u> to <u>June 25</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>June 25</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Eugene J. Strasser M.D.</u> DEGREE				23B. DATE SIGNED <u>June 25, 1972</u>
23C. PHYSICIAN'S NAME (Type) <u>Eugene J. Strasser M.D.</u> DEGREE		23D. ADDRESS <u>Maryland General Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/27/72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1972</u>		25B. NAME OF REGISTRAR <u>John E. J. J.</u>		25C. FUNERAL DIRECTOR <u>Schimmek Funeral Homes, Inc.</u> ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>



FUNERAL DIRECTOR: IMPORTANT

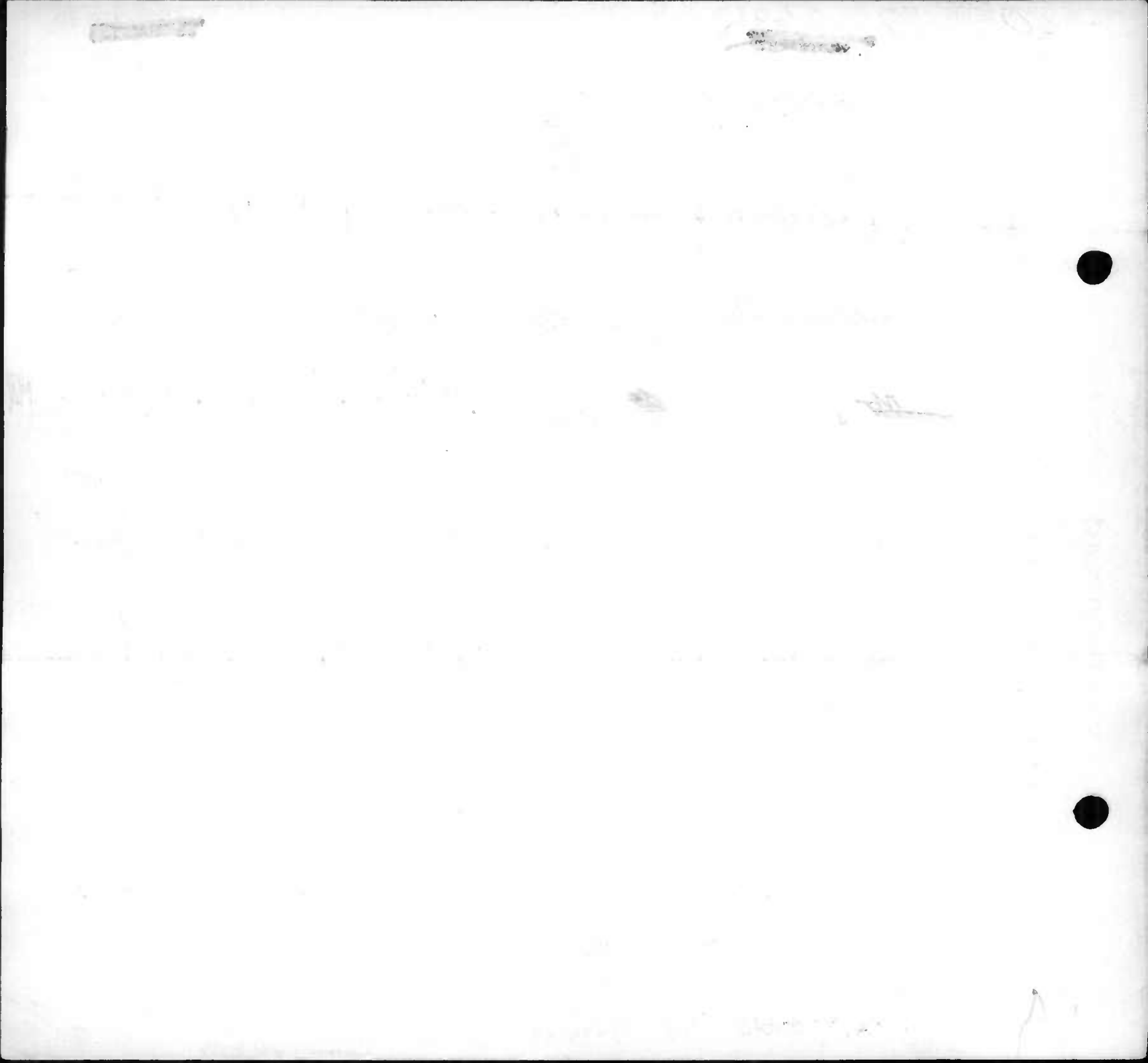
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
72 08947				72-06012	
BIRTH NO. 72-06012				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JOHN MICHAEL KILLMON JR.		JUNE 25/72		12 47 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Union Memorial Hosp.			Md. 1348		
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
MALE		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. BIRTHPLACE (State or foreign country)	
6/22/72		3		MARYLAND	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
MARYLAND		U.S.A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John M. Killmon			BARBARA Fisher SLAGER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NONE		NONE		John M. Killmon SR 1511 Union Ave.	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
II			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/22 1972 to 6/25 1972 that (I) (we) last saw the deceased alive on 6/25 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Edward H. Cahill MD			June 25, 1972		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
EDWARD H. CAHILL MD			1723 STELLA CT. BAL. MD		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		27 JUNE 72		ST. PETERS	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 28 1972		Robert E. Faber JR.		William R. Kleiber 3631 FALLS RD	
25D. LOCATION (City, town, or county) (State)					
BALTIMORE Md.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72-06013	
1. NAME OF DECEASED (Type or Print)		STONE, ANNE THERESA		2. DATE AND HOUR OF DEATH 6/22/72 700 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE		5300	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MD HOSPITAL 38 BALTIMORE MD		C. CITY OR TOWN CATONSVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2025 OLD FREDERICK RD.		5. SEX F		6. RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-12-06		9. AGE (In years last birthday) 65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Saleslady & Model-Dept. Store		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME PATRICK MCGUIRE		14. MOTHER'S MAIDEN NAME Margaret Mulryan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 820-02-7738		17. INFORMANT Charles E. Stone, Sr. - Catonsville, Md. Mr. & MRS. 2025 Old Frederick Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH 436.4 I (A) IMMEDIATE CAUSE CVA and pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Rheumatic heart disease & aortic fibulitis DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/23 1972 to 6/22/72 that (I) (we) last saw the deceased alive on 6/22 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. A. Fleming MD		23B. DATE SIGNED 6/22/72		23C. PHYSICIAN'S NAME (Type) L. A. FLEMING MD	
23D. ADDRESS UNIVERSITY HOSP.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/72	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUN 28 1972	
25A. NAME OF REGISTRAR Robert E. Fisher, Jr.		25B. FUNERAL DIRECTOR Burling Funeral Estate		25C. ADDRESS 736 Edmondson Ave. Catonsville, Md. 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72-06014</u>	
BIRTH NO. <u>72-06014</u>				2. DATE AND HOUR OF DEATH <u>JUNE 24 1972</u> <u>12:45A</u> M.			
1. NAME OF DECEASED (Type or Print) <u>GUILLIONI, ANNIBALE</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>BALTO. MD</u> B. COUNTY <u>BALTO COUNTY</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST. AGNES HOSPITAL</u>				C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <u>2826 MICHIGAN AVE.</u>				F. CITY <u>BALTO MD</u>			
5. SEX <u>MALE</u>		6. RACE <u>CAUCASIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-99</u>	
9. AGE (in years last birthday) <u>72</u>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTING</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>				13. FATHER'S NAME <u>Peter Giulioni</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>212348996</u>				17. INFORMANT <u>WILKENS AND CATON AVE.</u> ADDRESS <u>ST AGNES HOSPITAL RECORDS</u>			
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of death, but heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, which gave rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION GIVEN IN PART I. <u>CHIEF OF MEDICAL EXAMINER</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>RESPIRATORY FAILURE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>M.I.</u> (C) <u>A.S.C.U.D.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 h.</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JUNE 8</u> 19 <u>72</u> to <u>JUNE 24</u> 19 <u>72</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JUNE 24</u> 19 <u>72</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. J. Mol.</u>				23B. DATE SIGNED <u>6/27</u>		23C. PHYSICIAN'S NAME (Type) <u>JACOBUS MOL</u>	
23D. ADDRESS <u>ST AGNES HOSPITAL</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>6/27/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1972</u>	
25B. NAME OF REGISTRAR <u>P. A. E. J. B. M.</u>		25C. FUNERAL DIRECTOR <u>George J. Gonce</u>		25D. ADDRESS <u>4001 Ritchie Hwy., Baltimore, Md. 21225</u>			

2001

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08-07-11

YAT 1.

Figure 1

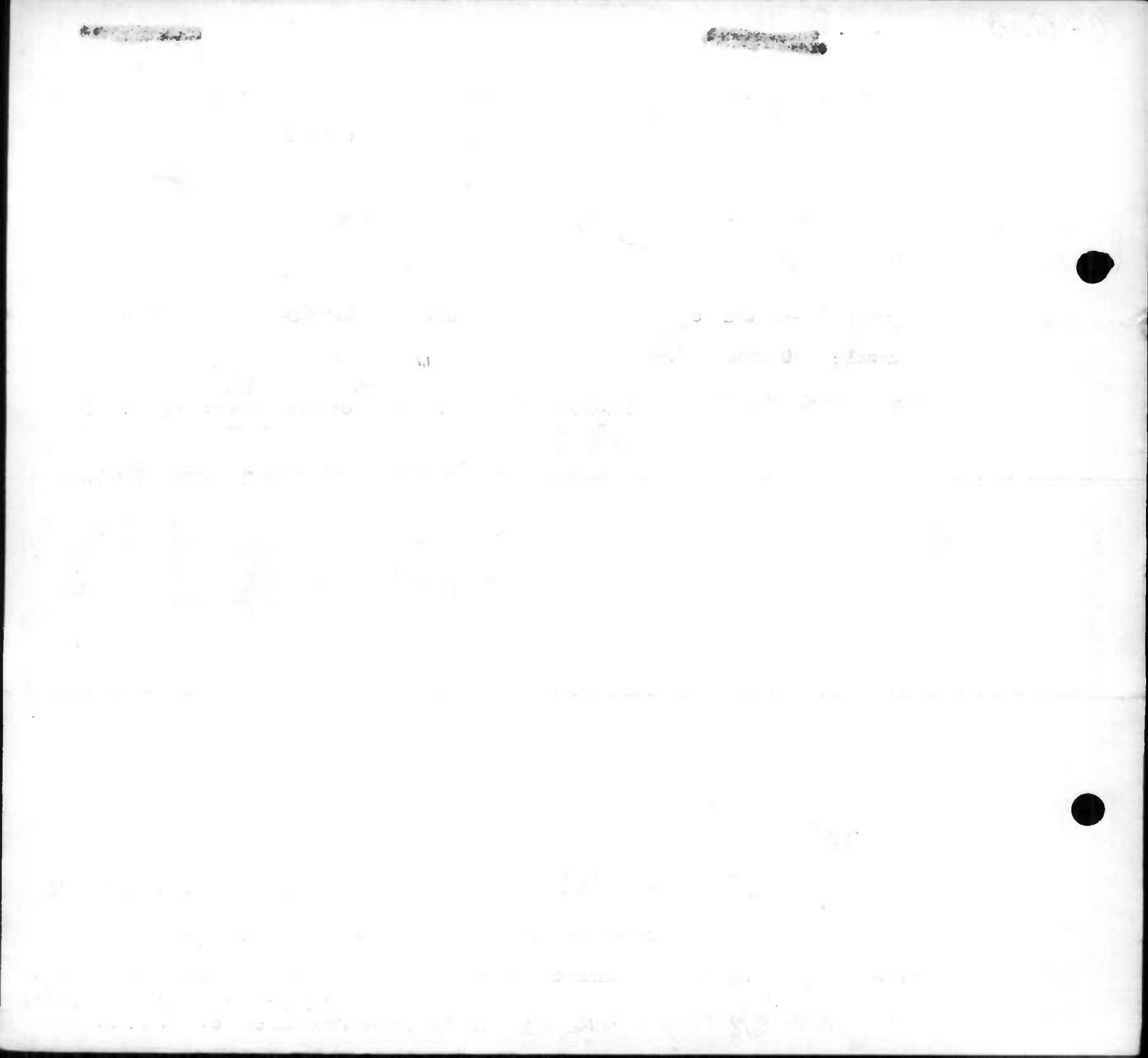
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JON 24/5/31

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

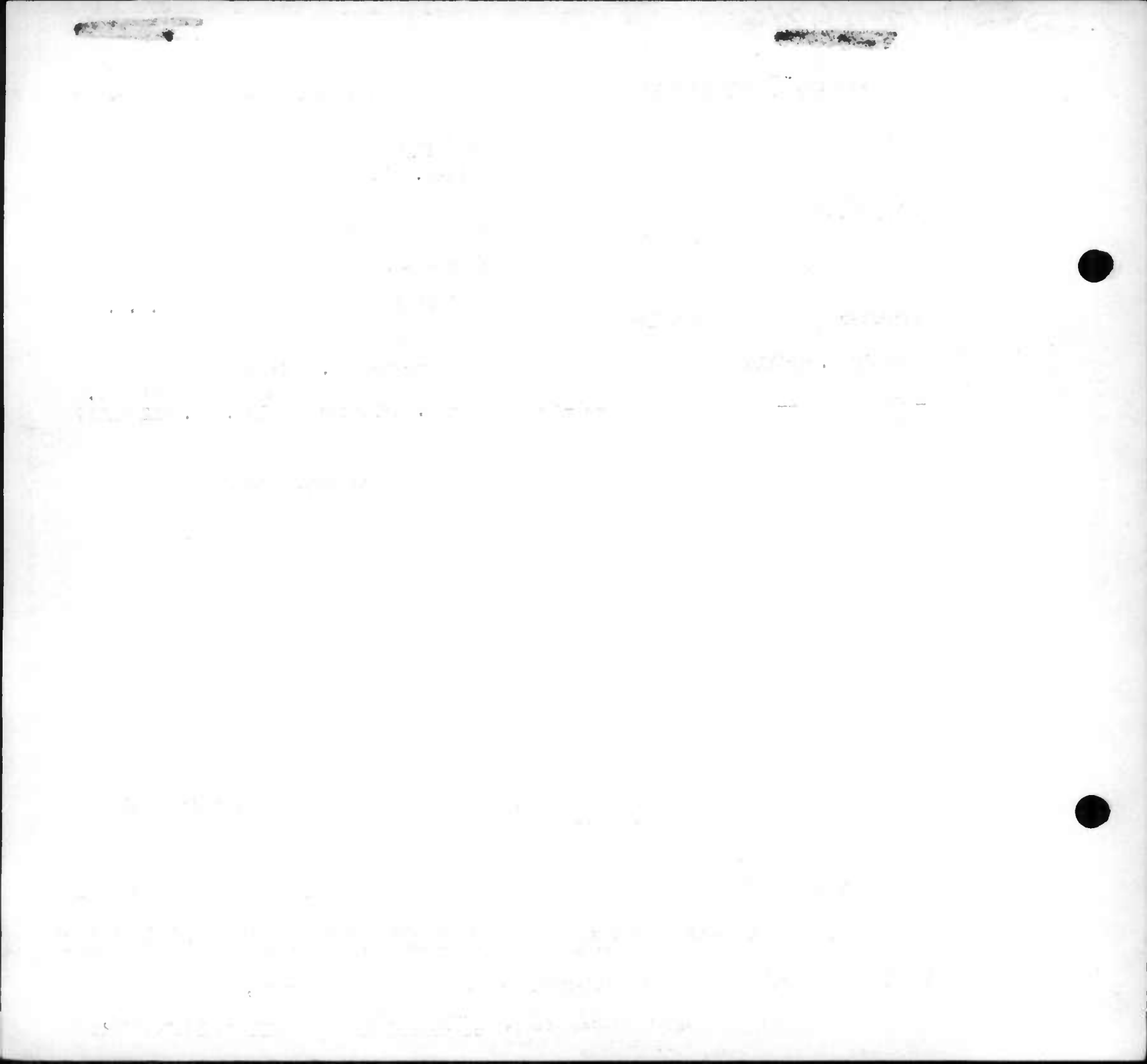
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. [REDACTED]	
BIRTH NO. [REDACTED] 12-06015					
1. NAME OF DECEASED (Type or Print) <u>Crouse, Leroy Thomas Sr.</u>			2. DATE AND HOUR OF DEATH <u>25 June 1972</u> <u>3 30</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University of Maryland hosp</u>			A. STATE <u>MD</u> B. COUNTY <u>Carroll</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Taneytown</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>Rt 1 Box 261</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-20</u>	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel T. Crouse, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Genevieve Adams</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes World War II</u>		16. SOCIAL SECURITY NO. <u>212-12-6350</u>		17. INFORMANT <u>Route 1 Box 261</u> ADDRESS <u>Mrs. Minnie Crouse Taneytown, Md. 21787</u>	
18. <u>412-3 I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:		
(C) <u>coronary artery disease</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley A. Morrison MD</u>			23B. DATE SIGNED <u>25 June '72</u>		
23C. PHYSICIAN'S NAME (Type) <u>STANLEY A. MORRISON MD</u>			23D. ADDRESS <u>Univ of Md hosp</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/28/1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Woodlawn Baltimore Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1972</u>		25B. NAME OF REGISTRAR <u>R. E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>8728 Liberty Road</u> ADDRESS <u>21139 Loring Byers Funeral Directors, P. A.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72-06076</u>	
BIRTH NO. <u>72-06016</u>		1. NAME OF DECEASED (Type or Print) <u>MARY T. HEILMAN.</u>		2. DATE AND HOUR OF DEATH <u>6-16-72</u> <u>9:50 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md</u> 833 8. COUNTY <u>2854</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Balto. City</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>213-D. Atholgate Lane.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11-21</u>	9. AGE (In years last birthday) <u>50</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Jewelry</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Dennis J. Grillo</u>		
14. MOTHER'S MAIDEN NAME <u>Margaret M. Keiser</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>- No</u>		
16. SOCIAL SECURITY NO. <u>217-07-3608</u>			17. INFORMANT <u>John E. Whitaker</u> ADDRESS <u>213 D Alholgate Rd. Balto. Md. 21229</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CA. OF COLON. (METASTATIC)</u>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-25-72</u> 19 to <u>6-26-72</u> 19 that (I) (we) last saw the deceased alive on <u>6-26-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>6-26-72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>FAYAZ AHMED FAIZ</u>			23D. ADDRESS <u>LUTHERAN HOSPITAL OF MARYLAND, 730 ASHBURTON STREET, BALTIMORE 21216.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>06/29/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Harry Witke</u> ADDRESS <u>4112 Columbia Pike</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72-06017	
BIRTH NO. 72-06017				2. DATE AND HOUR OF DEATH JUNE 27, 1972 11:45A M.			
1. NAME OF DECEASED (Type or Print) SCHYMANSKY, ANTOINETTE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				C. CITY OR TOWN CATONSVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE 6. RACE CAUCASIAN 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 01/06/15		9. AGE (In years last birthday) 57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STANLEY RADWANSKI				14. MOTHER'S MAIDEN NAME EVA RADWANSKI			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE				16. SOCIAL SECURITY NO. 217-07-7825		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. 207.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bleeding / generalized LEUKEMIA (B) DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): _____							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NONE		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MAY 30 19 72 to JUNE 27 1972, that (I) (we) last saw the deceased alive on JUNE 27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Guillermo G. Romero MD				23B. DATE SIGNED 6-27-72			
23C. PHYSICIAN'S NAME (Type) E ROMERO, M.D.				23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/72		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1972		25B. NAME OF REGISTRAR P. A. E. Fabelo MD		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue		ADDRESS 21228	

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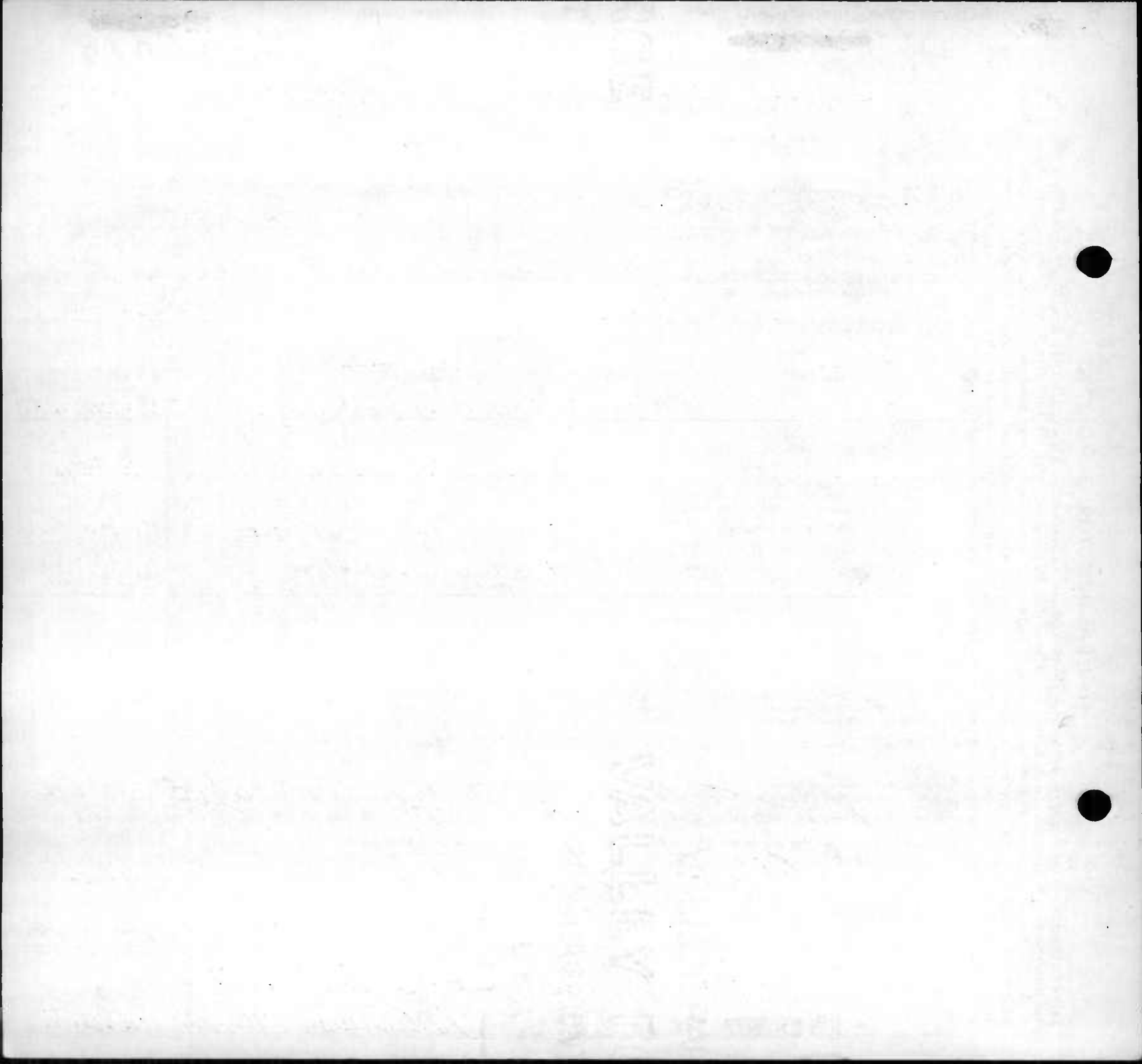
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

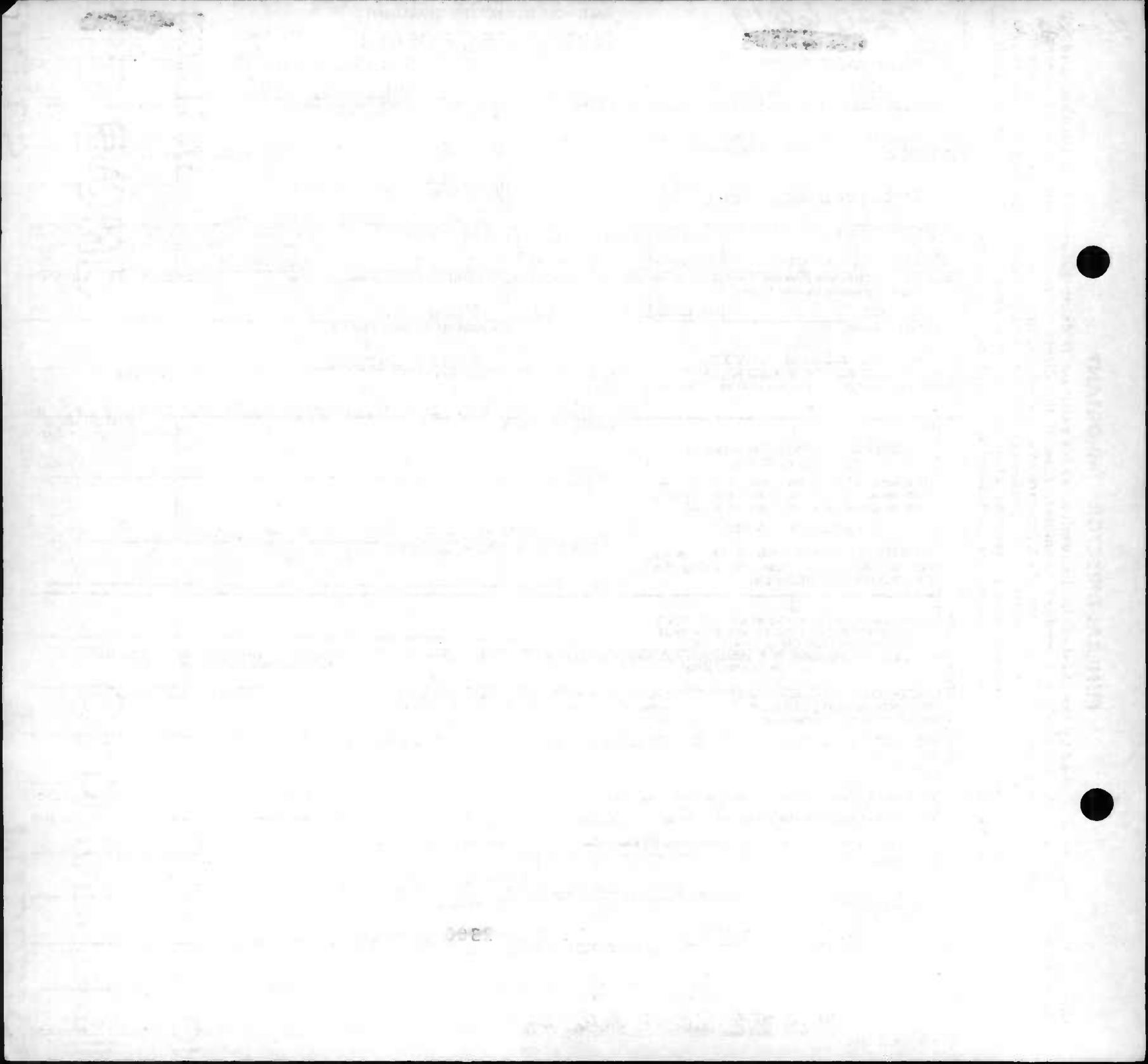
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 72-06018</p> <p>1. NAME OF DECEASED (Type or Print) JESSEE SCHAEFER</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 6/26/72 2:45P M.</p> </div> </div>											
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3719 NORTONIA RD.</p>						<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MD. B. COUNTY 1509</p> <p>C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 3719 NORTONIA RD.</p>					
5. SEX F		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/25/1880 91		9. AGE (In years last birthday)		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY HOME				11. BIRTHPLACE (State or foreign country) U.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unk						14. MOTHER'S MAIDEN NAME unk					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 229-40-8145		17. INFORMANT FLORENCE QUEEN-3719 NORTONIA RD. ADDRESS					
<p>18. 733.91 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE CVA (Thrombosis) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Chronic Brain Syndrome DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Diverticulosis - Colon</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days</p> <p>Unknown</p> <p>Unknown</p>											
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
<p>22. I certify that (I) (this hospital) attended the deceased from 9/1/72 1969 to 6/26 1972 that (I) (we) last saw the deceased alive on 6/26 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>											
23A. SIGNATURE E. E. Holt M.D.						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/27/72			
23C. PHYSICIAN'S NAME (Type) E. E. Holt						23D. ADDRESS 3715 Liberty High Ave., Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6/29/72		24C. NAME OF CEMETERY OR CREMATORY Arbutus View P.R.C.		24D. LOCATION (City, town, or county) Balto. Md.		(State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1972				25B. NAME OF REGISTRAR P.R. E. F. B. Jr.				25C. FUNERAL DIRECTOR Chatham-1701 M.C. Cullah St		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>72-06019</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72-06019</u>	
1. NAME OF DECEASED (Type or Print) <u>Curtis Bland Davis</u>				2. DATE AND HOUR OF DEATH <u>June 25, 1972</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>1605</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2323 W. Lafayette Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1914</u>	9. AGE (In years last birthday) <u>57</u>	10. Under 1 Yr. Months: <u> </u> Days: <u> </u>	11. Under 24 Hrs. Hours: <u> </u> Min: <u> </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>checker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Bethelham Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Emmett Bland Davis</u>				14. MOTHER'S MAIDEN NAME <u>Addie Barner</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-03-2426</u>		17. INFORMANT <u>Mrs. Ida O. Davis</u>	
				ADDRESS <u>2323 W. Lafayette Ave.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>410.9 I</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute M. I.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic Heart Disease 2 1/2 years</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u> </u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u> </u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u> </u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u> </u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u> </u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u> </u>			
22. I certify that (I) (this hospital) attended the deceased from <u>August 27 1963</u> to <u>June 25 1972</u> that (I) (we) last saw the deceased alive on <u>June 21 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Roland T. Smoot, M.D.</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6/27/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Roland T. Smoot</u>				23D. ADDRESS <u>M. D. 2300 Garrison Blvd.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-29-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 72-06020		DEATH NO. 72-06020	
1. NAME OF DECEASED (Type or Print) Theodore R. Edwards		2. DATE AND HOUR OF DEATH 6-25-72 1:00 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2001	
FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT Hospital, Inc. 2600 Liberty Heights Ave		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/28/07 9. AGE (in years, lost birthday) 64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
10B. KIND OF BUSINESS OR INDUSTRY Allied Bedding		12. CITIZEN OF WHAT COUNTRY U.S.A..	
13. FATHER'S NAME William Edwards		14. MOTHER'S MAIDEN NAME Annie Ruffin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-034801	
17. INFORMANT Mrs. Rosie Edwards		ADDRESS 1808 W. Saratoga St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe Abdominal distress of 2 days (B) DUE TO, OR AS A CONSEQUENCE OF: Unknown cause (C) HASCD & Medicated death 6 mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 12, 1972 to June 25, 1972 that (I) (we) last saw the deceased alive on June 25, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. R. Abousey		23B. DATE SIGNED June 26, 1972	
23C. PHYSICIAN'S NAME (Type) Dr. Abousey		23D. ADDRESS Provident Hospital 2600 Liberty Height Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-1972	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1972		25B. NAME OF REGISTRAR Robert E. Talley, RD	
25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE.			

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4. TYPE OF CASE CRIMINAL

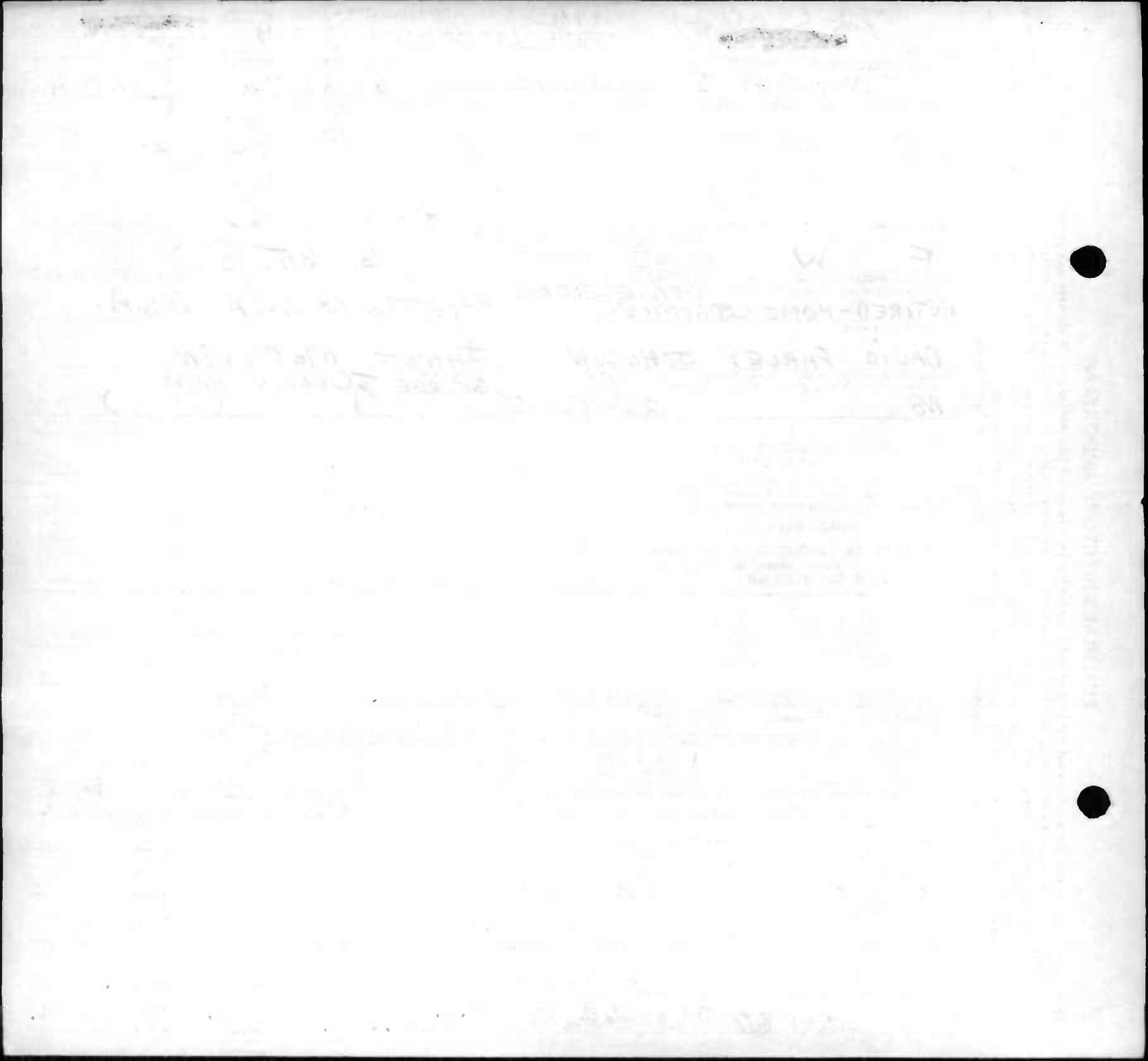


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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72-06021		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72-06021	
1. NAME OF DECEASED (Type or Print) MARTHA J. CUNNINGHAM			2. DATE AND HOUR OF DEATH 6-28-72 12:01 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 MARYLAND GENERAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE MD B. COUNTY BALT. C. CITY OR TOWN BALT. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3024 NCALVERT ST.		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-06	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GEN. ELECTRIC RETIRED - HOME ECONOMIST			11. BIRTHPLACE (State or foreign country) FAYETTE CO., W. VA.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME DAVID FARLEY JOHNSON		
14. MOTHER'S MAIDEN NAME JANET McOLVIN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 232-05-2615			17. INFORMANT GEORGE J. CUNNINGHAM (HUSBAND)		
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE METASTATIC DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA, PRIMARY SITE UNKNOWN. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-15-1972 to 6-28-1972 that (I) (we) last saw the deceased alive on 6-28-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Grasso M.D.				23B. DATE SIGNED 6-28-72	
23C. PHYSICIAN'S NAME (Type) MICHAEL GRASSO M.D.				23D. ADDRESS Maryland General Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/72		24C. NAME of CEMETERY or CREMATORY Louisa Park	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 28 1972			
25B. NAME OF REGISTRAR Robert E. Faber, Jr.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 145231	
BIRTH NO. 72 06022		1. NAME OF DECEASED (Type or Print) <i>Mills, OIA Hattie</i>		2. DATE AND HOUR OF DEATH <i>6/22/72</i> 4:00 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>1214 Eakin Place</i> B. COUNTY <i>1901</i>		C. CITY OR TOWN <i>1901</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bon Secours Hospital</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER	
5. SEX <i>Female</i>	6. RACE <i>B</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/19/06</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>N. Carolina</i>	
13. FATHER'S NAME <i>Will Mills</i>		14. MOTHER'S MAIDEN NAME <i>Janie Johnson</i>		12. CITIZEN OF WHAT COUNTRY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-30-8460</i>		17. INFORMANT ADDRESS	
18. <i>412.31</i> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary heart failure</i>			
ANTECEDENT CAUSES		(B) <i>Arteriosclerotic heart disease</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Anemia; uremia; severe pneumonia</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>(No)</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE INJURY OCCURRED (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-18</i> 19 <i>72</i> to <i>6-22</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>6-22</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Putchara</i> <i>M.D.</i>		23B. DATE SIGNED <i>6-22-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>PUTCHARA</i>		23D. ADDRESS <i>BON SECOURS HOSPITAL BALTO MD 21223</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>6/24/72</i>		24C. NAME of CEMETERY or CREMATORY <i>W.A. Calverley Cem.</i>	
24D. LOCATION (City, town, or county) <i>W.A. County, Maryland</i>		24E. (State) <i>Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 29 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>1712 W. North</i>	

34 N. Bruce

4/12/72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

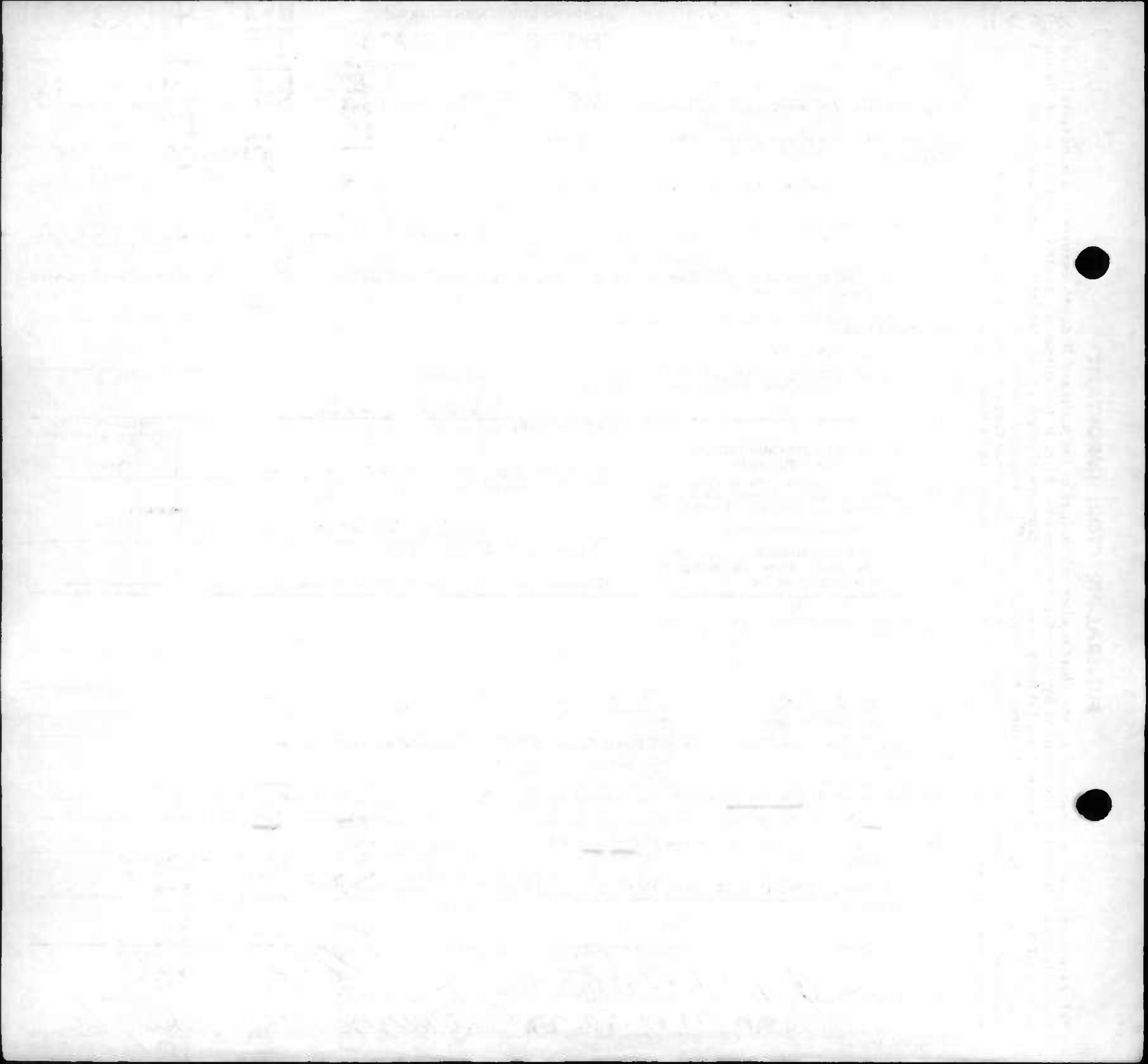
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72 06023

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 06023

BIRTH NO. 72 06023		2. DATE AND HOUR OF DEATH 6/27/72 8:15 A.M.	
1. NAME OF DECEASED (Type or Print) CORCORAN HAMPTON (Mrs. Inez)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 807	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/99 9. AGE (In years last birthday) 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) ASH LAND, VIRGINIA	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM TAYLOR		14. MOTHER'S MAIDEN NAME LILLIE HUGHES	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 2	
17. INFORMANT Josephine Bell		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, senility, etc. It means the disease, injury or complication which caused death.) I 436.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebral edema DUE TO, OR AS A CONSEQUENCE OF: DAYS (B) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF: DAYS (C)	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (mostly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from 6/24 19 72 to 6/27 19 72 that (I) (we) last saw the deceased alive on 6/27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert C. Bass Jr MD		23B. DATE SIGNED 6/27/72	
23C. PHYSICIAN'S NAME (Type) ROBERT C. BASS, JR MD		23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-72	
24C. NAME of CEMETERY or CREMATORY White Mt Park		24D. LOCATION (City, town, or county) (State) Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR R. A. E. Feltner	
25C. FUNERAL DIRECTOR		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

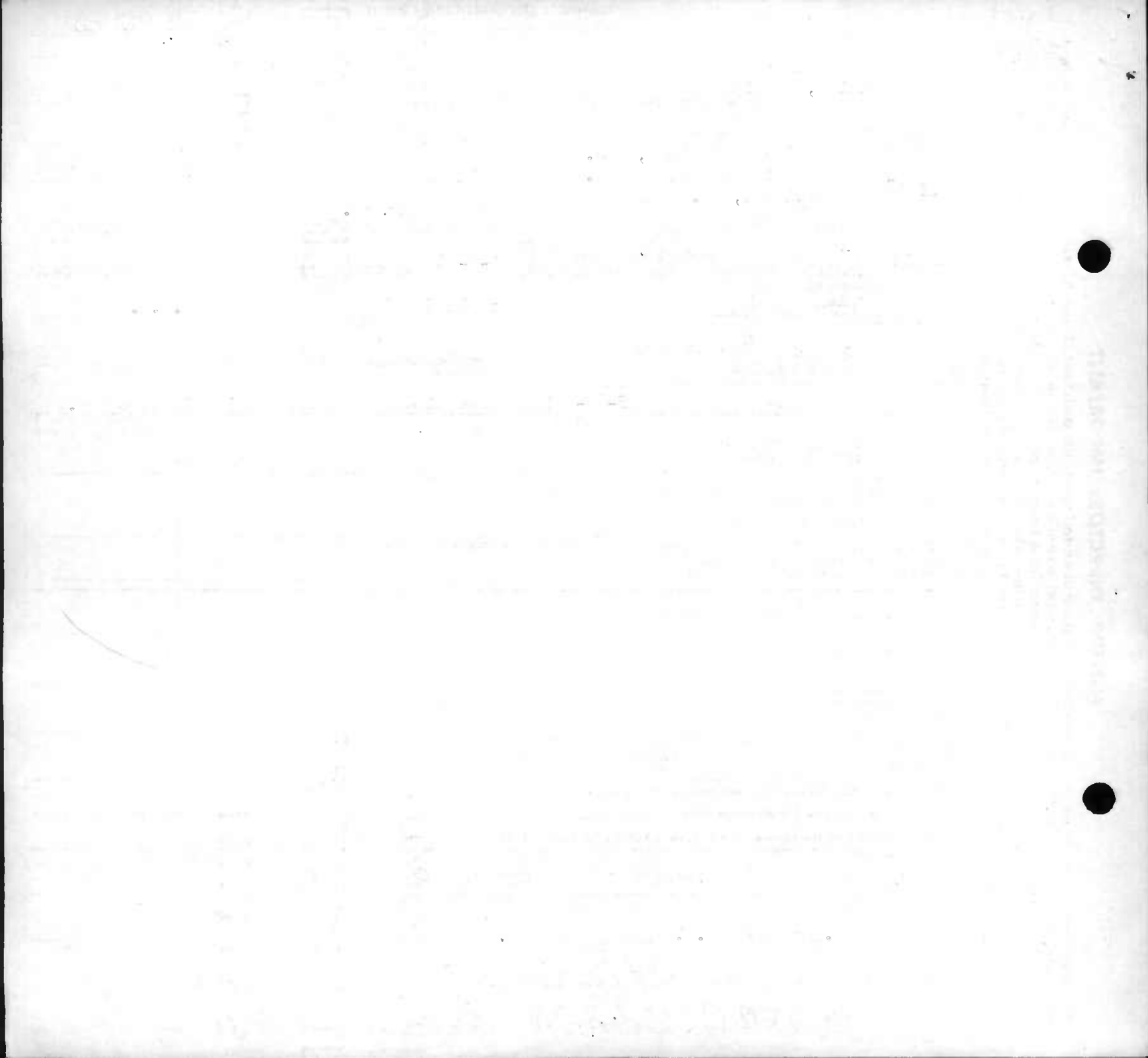
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06024	
1. NAME OF DECEASED (Type or Print) <u>William Mason</u>		2. DATE AND HOUR OF DEATH <u>6/22/72</u> <u>12 15</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nursing Home</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1400 John Street</u> <u>Baltimore, Maryland.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>603</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2234 Orleans Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/75</u>	9. AGE (In years <u>97</u> lost birthday <u>95</u>)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Nurse</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Accomack County Va. U.S.A</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE STRAND</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Rosalee Mason</u> ADDRESS <u>N. York</u>	
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Chronic lung disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>arteriosclerosis generalized</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/12/71</u> 19 <u>71</u> to <u>6/22</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6/21</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alan H. Macart</u>		23B. DATE SIGNED <u>6/23/72</u>		23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MACART MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>6-28-72 Burial</u>		24B. DATE <u>6/28/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cmt</u>	
24D. LOCATION (City, town, or county) (State) <u>AA County MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1972</u>		25B. NAME OF REGISTRAR <u>AC 3.0</u>	
25C. FUNERAL DIRECTOR <u>William Brantley Jr</u>		25D. ADDRESS <u>25 Reed St Baltimore MD</u>			

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 72 Q6025		CITY HEALTH DEPARTMENT		REG. NO. 72 Q6025	
1. NAME OF DECEASED (Type or Print) LOVEY <i>Watkins, Lovely E.</i>		2. DATE AND HOUR OF DEATH 6/22/72 9:30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2534			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-2-94		9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HENRY BROOKS		14. MOTHER'S MAIDEN NAME Josephine Brooks			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-2738		17. INFORMANT Rose Hines (Daughter) ADDRESS 1411 Valentino Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF PANCREAS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA OF LIVER ARTERIOSCLEROSIS & MYOCARDITIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 6/22/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/13 19 72 to 6/22 19 72 that (I) (we) last saw the deceased alive on 6/22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gilbert L. Banfield		23B. DATE SIGNED 6/22/72		23C. PHYSICIAN'S NAME (Type) A. Banfield M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-27-72		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cmt	
24D. LOCATION (City, town, or county) CC County Md		24E. STATE Md		24F. ADDRESS 1000 Brantley Ave	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR JOHN E. JAMES		25C. FUNERAL DIRECTOR CONRADSON	



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72 Q6026

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 Q6026

REG. NO.

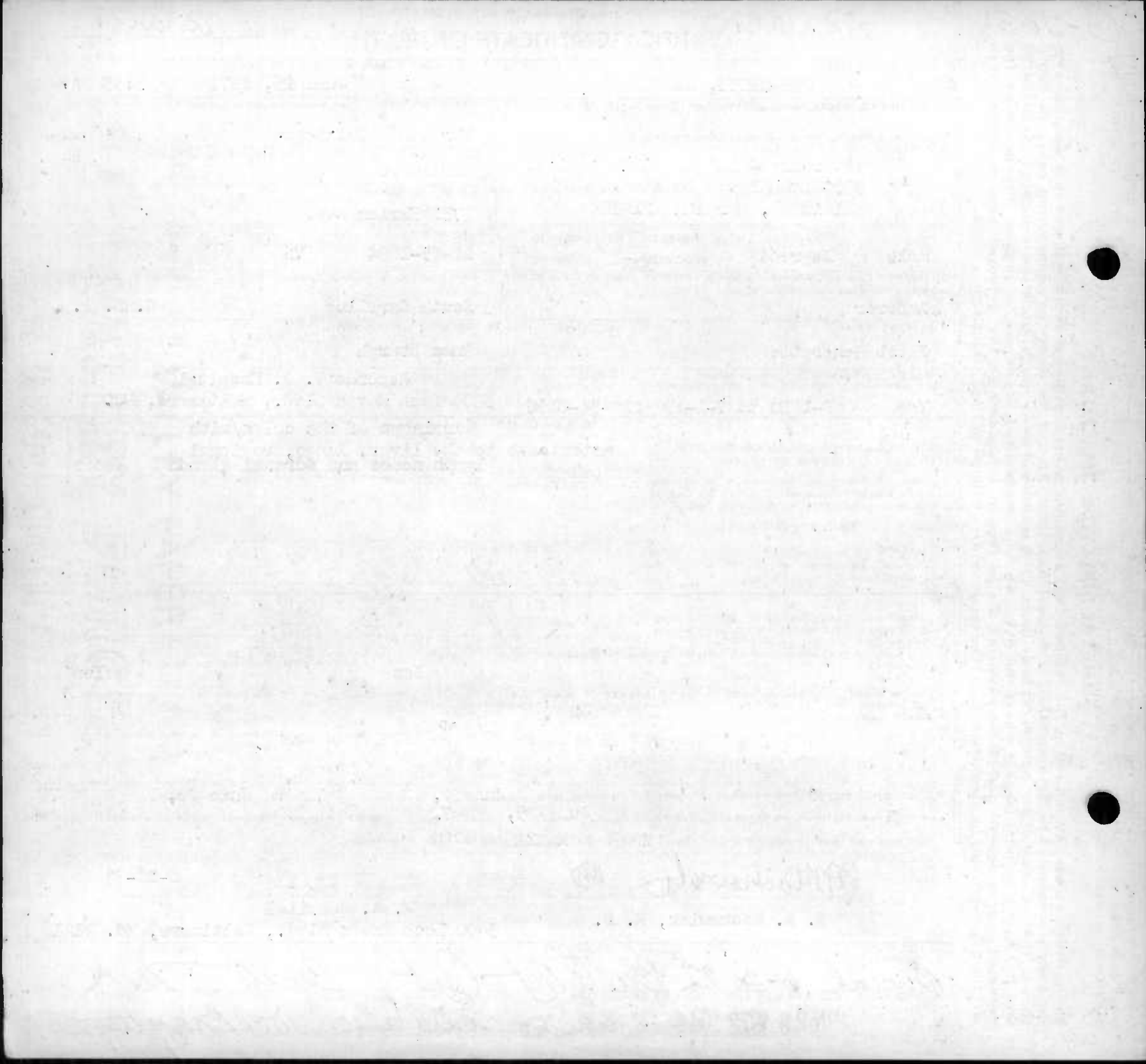
BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK M. DIGGS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 251 Herring Ct.		3. DATE PRONOUNCED DEAD Month Day Year Hour June 23, 1972 1:20 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Jan. 15, 1887		10. AGE (In years lost birthday) 85	
11. BIRTHPLACE (State or foreign country) U.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY None	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-18-4648	
15. MOTHER'S MAIDEN NAME Unknown		18. INFORMANT ADDRESS James Diggs 1829 Rutland Ave.	
19. 712.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) DATE SIGNED 6/23/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-72	
24C. NAME of CEMETERY or CREMATORY MT. Calvary C.		24D. LOCATION (City, town, or county) (State) Brocklyn Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Cherry O. Wilson		ADDRESS 1000 Brantley Ave. Balt. Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 Q6027				CITY HEALTH DEPARTMENT		REG. NO. 72 Q6027	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GENERETTE, NAMON				2. DATE AND HOUR OF DEATH June 25, 1972 3:55 A.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2738 Harlem Ave.							
5. SEX Male	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-1894	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Jacob Generette				14. MOTHER'S MAIDEN NAME Emma Bourgh			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8-1-18 to 7-1-19				16. SOCIAL SECURITY NO. 212-34-8296		17. INFORMANT Records V. A. Hospital ADDRESS 3900 Loch Raven Blvd., Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of the colon with metastases to the liver, lungs, regional lymph nodes and adrenal glands (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 2, 1972 to June 25, 1972 , that (I) (we) last saw the deceased alive on June 25, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.							
23A. SIGNATURE P. A. Mackowiak				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-26-72	
23C. PHYSICIAN'S NAME (Type) P. A. Mackowiak, M. D.				23D. ADDRESS V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-30-72		24C. NAME OF CEMETERY OR CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR P. A. Mackowiak		25C. FUNERAL DIRECTOR Edouard 1007 Brantley		ADDRESS	



1
14-630

72 06028

BALTIMORE CITY HEALTH DEPARTMENT

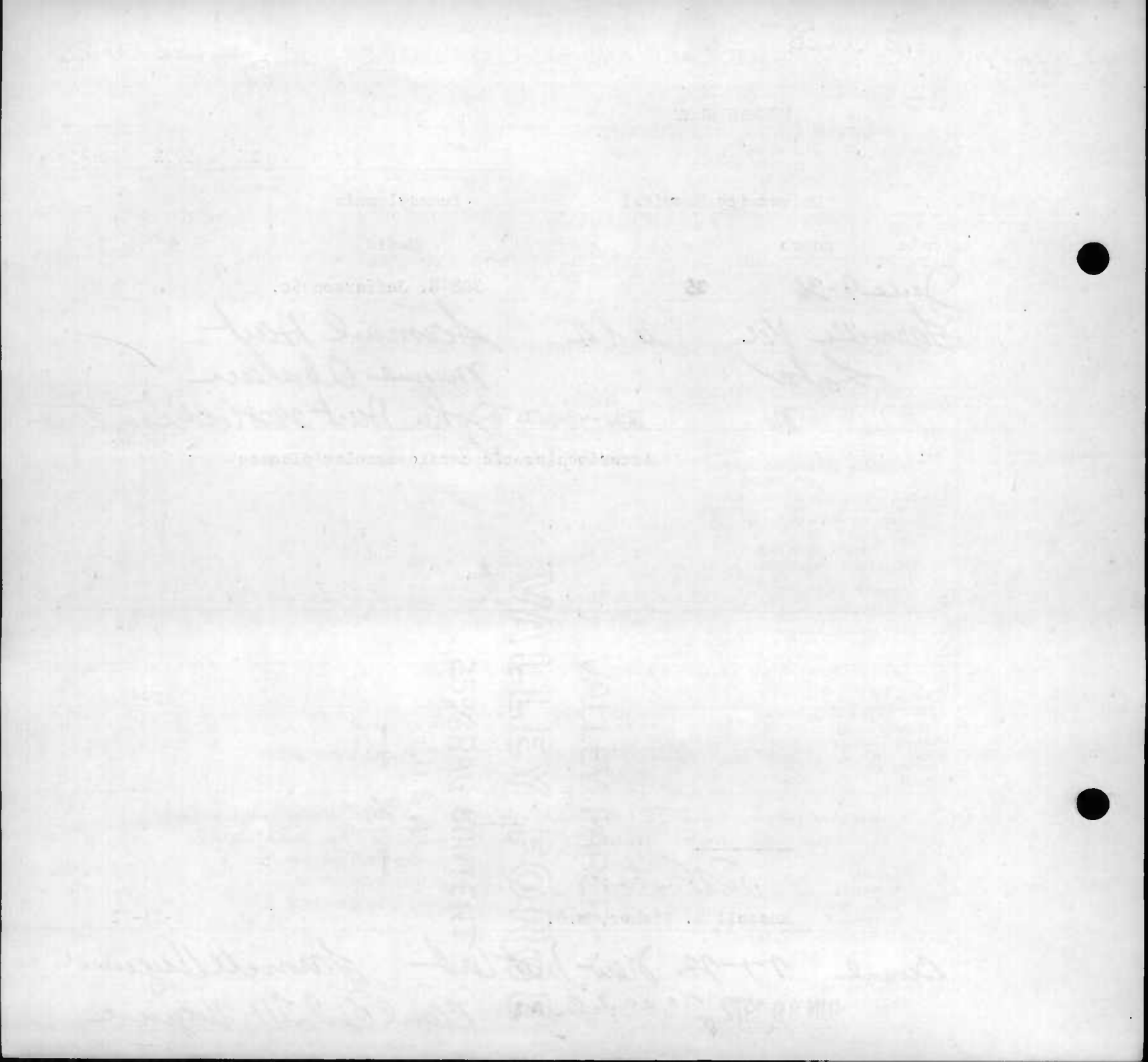
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 06028

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NORMAN HURT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 25 1972 11:45p M.	
6. SEX male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE negro		C. CITY OR TOWN Media	
9. DATE OF BIRTH June 9-36		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 36		E. STREET AND NUMBER 308 E. Jefferson St.	
11. BIRTHPLACE (State or foreign country) Lanville Va		13. FATHER'S NAME Samuel Hurt	
14A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Lab		15. MOTHER'S MAIDEN NAME Minne Abraham	
14B. KIND OF BUSINESS OR INDUSTRY		18. INFORMANT John Hurt 2928 Cold Spring Lane	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		17. SOCIAL SECURITY NO. 226-48-9535	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		21. AUTOPSY? (Yes or No) yes	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R. S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-26-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-72	
24C. NAME OF CEMETERY or CREMATORY New Mt Cal		24D. LOCATION (City, town, or county) (State) Lanville Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR R. S. Fisher, M.D.	
25C. FUNERAL DIRECTOR Blair Road FH Virginia		ADDRESS	



C-4201

72 Q6028

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 Q6028

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ROBERT J. CLOSE

2. DATE AND HOUR OF DEATH

6-25-72 7:20 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

THE GOOD SAMARITAN HOSP

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

1427 Hull St.

C. CITY OR TOWN

Baltimore, Md.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1427 HULL ST.

5. SEX

M

6. RACE

C

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

07-19-98

9. AGE (In years
last birthday)

73

10 Under 1 Yr.

Months Days

11 Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

U.S. Army

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Illinois

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Perceval Close

14. MOTHER'S MAIDEN NAME

Gray, Sadie

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

World War I

16. SOCIAL
SECURITY NO.

212-28-6274

17. INFORMANT

Elizabeth J. Close 1427 Hull St.

ADDRESS

18. 1990 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

METASTATIC CARCINOMA

Primary site unknown

(B)

DUE TO, OR AS A CONSEQUENCE OF:

CORONARY ARTERY DISEASE

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

CORD.

19A. DATE OF OPERATION

6-12-72

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Aortic

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, locality, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-12 1972 to 6-25 1972
that (I) (we) last saw the deceased alive on 6-25 1972 and that in (my) (our) opinion death occurred on the date
and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. W. W. M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-25-72

23C. PHYSICIAN'S
NAME (Type)

DR RUPAK C. MITRA M.D.

DEGREE

23D. ADDRESS

The Good Samaritan Hospital,
Baltimore24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/29/72

24C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUN 29 1972

25B. NAME OF REGISTRAR

D. A. E. F. J. M.D.

25C. FUNERAL DIRECTOR

Charles E. Stevens Funeral Home, Inc.
801 E. Fort Avenue

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11.2.1904

Robert Allen

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 Q6030	
BIRTH NO. 72 Q6030		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Wright, John		2. DATE AND HOUR OF DEATH 6-26-72 1:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD PROVIDENT HOSPITAL, INC. 2600 LIBERTY HEIGHT AVE. BALTIMORE, MD. 21215		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1504	
5. SEX Male		6. RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-25-00	
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bolden		14. MOTHER'S MAIDEN NAME Lula Cook	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-28-1379	
17. INFORMANT Mrs. Martha Landon (Siter)		ADDRESS 2418 Reisterstown Rd.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Infarction.			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-11-72 to 6-26-72 that (I) (we) last saw the deceased alive on 6-26-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE R. Roa M.D.		23B. DATE SIGNED 6-26-72	
23C. PHYSICIAN'S NAME (Type) R. Roa M.D.		23D. ADDRESS Provident Hospital 2600 Liberty Height Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/72	
24C. NAME OF CEMETERY OR CREMATORY Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Adolphus Halstead	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

7-24-1972 - Correction form from Adolphus Halstead - Funeral Director. HRS
1206 W. North Ave., Balto., Md.

W-300.72-06031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

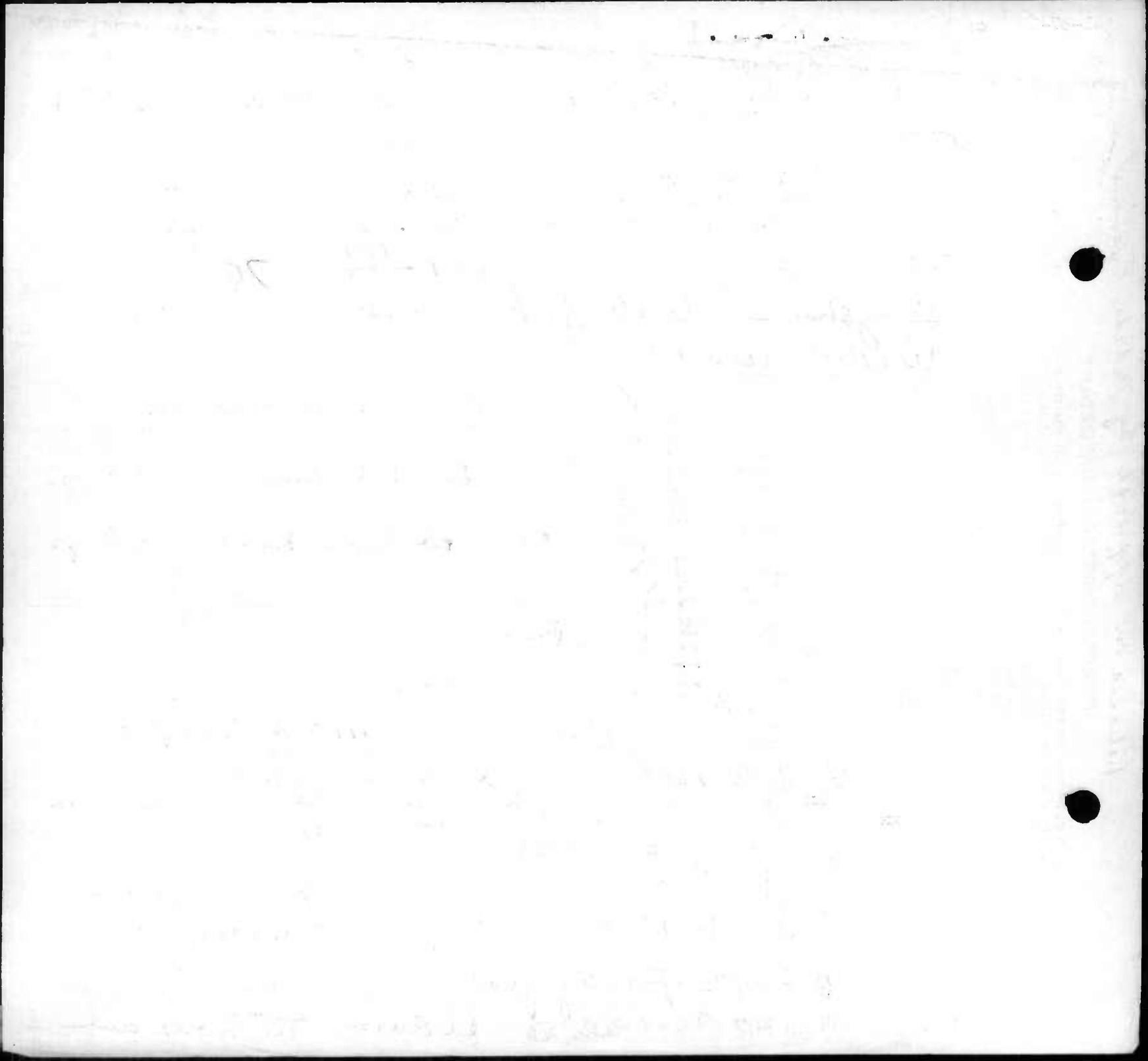
72 06031

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>John Waddy</u>		2. DATE AND HOUR OF DEATH <u>June 14, 1972</u> <u>1254</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1601</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>			6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>July 1, 1902</u>		9. AGE (In years last birthday) <u>69</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Songster</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Water furb</u>		11. BIRTH PLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Willie Waddy</u>		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT BCH RECORDS: 4940 Eastern Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>E898X1</u> <u>Renal failure</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>45% 3rd degree burns</u>			DUE TO, OR AS A CONSEQUENCE OF: <u>3 days</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Pneumonia</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>1119 N. Carey St. 1601</u>	
21D. TIME OF INJURY (APPROX.) <u>6 11 72</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Smoking in bed</u>	
22. I certify that <u>100</u> (this hospital) attended the deceased from <u>June 11</u> 19 <u>72</u> to <u>June 14</u> 19 <u>72</u> that <u>100</u> (we) last saw the deceased alive on <u>June 14</u> 19 <u>72</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) <u>not</u> view the body after death.					
23A. SIGNATURE <u>Jack K. Roth</u>				23B. DATE SIGNED <u>6/14/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jack K. Roth</u>				23D. ADDRESS <u>Baltimore City Hospital</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24B. DATE <u>6/19/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Family plot</u>	
24D. LOCATION <u>Location Co Va</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>11/29/72</u>		25B. NAME OF REGISTRAR <u>P. A. E. F. B. R. R.</u>		25C. FUNERAL DIRECTOR <u>2222 W. 7th Ave</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released on approval by Medical Examiner

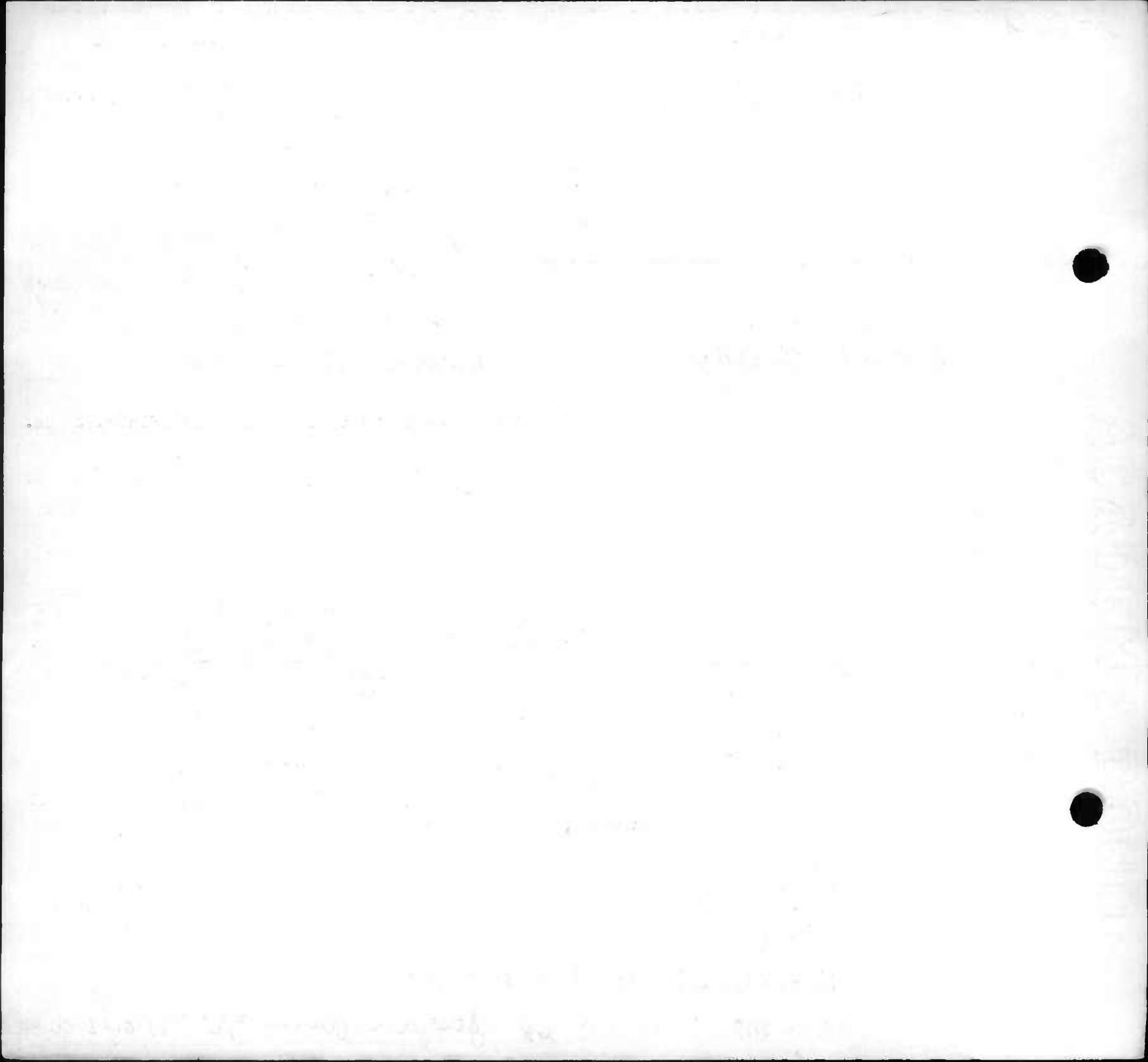


FUNERAL DIRECTOR: IMPORTANT

VS 150-REV. 1/1/68

REG. NO. 72 06032

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CLARA BOWIE		June 18, 1972 7:12 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
		A. STATE Maryland B. COUNTY 1537			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
39 Prominent Hospital Baltimore, Md.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
3323 Piedmont Av.					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F	B	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/29/04	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Basil GRAY		ANNIE GOLDER		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		216-10-1407		James Bowie (Husband) 3323 Piedmont Ave.	
18. 2500 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Diabetic Acidosis 24 hours or less			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ? Arterial Thrombosis 1 week			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Acute Myocardial Infarction with 45 min			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 19 72 to 6/18 19 72 that (I) (we) last saw the deceased alive on June 18, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
D. W. STEWART, M.D.				6/18/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
D. W. STEWART, M.D.				2300 Garrison Blvd.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
B		6/23/72		Arbutus mem pht	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 29 1972		D. A. E. J. E. J.		Rosen 2222 N. Orleans Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 Q6033</u>	
BIRTH NO. <u>72 Q6033</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ANNA MARIE HOWARD			2. DATE AND HOUR OF DEATH 6-17-72 11:30 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1504 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1900 N. PAYSON ST.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-56	9. AGE (In years last birthday) 16	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME LOVETT HOWARD			14. MOTHER'S MAIDEN NAME ANN MARIE HOWARD HAWKINS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Georgia Lovett ADDRESS 1900 N. Payson St.		
18. 746.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Pulmonary edema, Renal failure (C) VSD - Open Heart Repair APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6/12/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED VSD		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 0	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 0		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 0	
22. I certify that (I) (this hospital) attended the deceased from 6/11 19 72 to 6/17 19 72 that (I) (we) last saw the deceased alive on 6/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Levi Watkins Jr.			23B. DATE SIGNED 6/17/72		
23C. PHYSICIAN'S NAME (Type) LEVI WATKINS JR. M.D.			23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-26-72		24C. NAME OF CEMETERY OR CREMATORY Muirkerk	
24D. LOCATION (City, town, or county) Md.		24E. STATE Md.		24F. ADDRESS 2222 N. Mt. G.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Dr. J. E. Jones		25C. FUNERAL DIRECTOR Joseph L. Russ	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 06034		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06034	
1. NAME OF DECEASED (Type or Print) <i>Eunice M. Morgan</i>			2. DATE AND HOUR OF DEATH <i>6-22-72</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>4104 Rokeby Road</i>			A. STATE <i>Maryland</i> B. COUNTY <i>1601</i>		
			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 4 1903</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Halefax, N. Carolina</i>	
13. FATHER'S NAME <i>George Hunt</i>			12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Dorine Harris</i>
					ADDRESS <i>4104 Rokeby Rd.</i>
18. <i>43391</i>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Vascular Occlusion Less than 8 hrs</i>		
ANTECEDENT CAUSES			(B) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>unknown</i>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <i>Sensitivity</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2-25</i> 19 <i>69</i> to <i>6-17</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>6-17</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John T. Chiselle</i>			23B. DATE SIGNED <i>6-26-72</i>		
23C. PHYSICIAN'S NAME (Type) <i>John T. Chiselle</i>			23D. ADDRESS <i>940 W. North Ave Baltimore Md 21217</i>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>6-26-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem.</i>	
<i>Burial</i>				24D. LOCATION (City, town, or county) (State) <i>3501 Suderick Ave. Balt., Md</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>John E. Fabin</i>		25C. FUNERAL DIRECTOR <i>Joseph L. Ruess</i>	
				ADDRESS <i>2222 W. North Ave</i>	

Address 1115 Edmondson Ave.

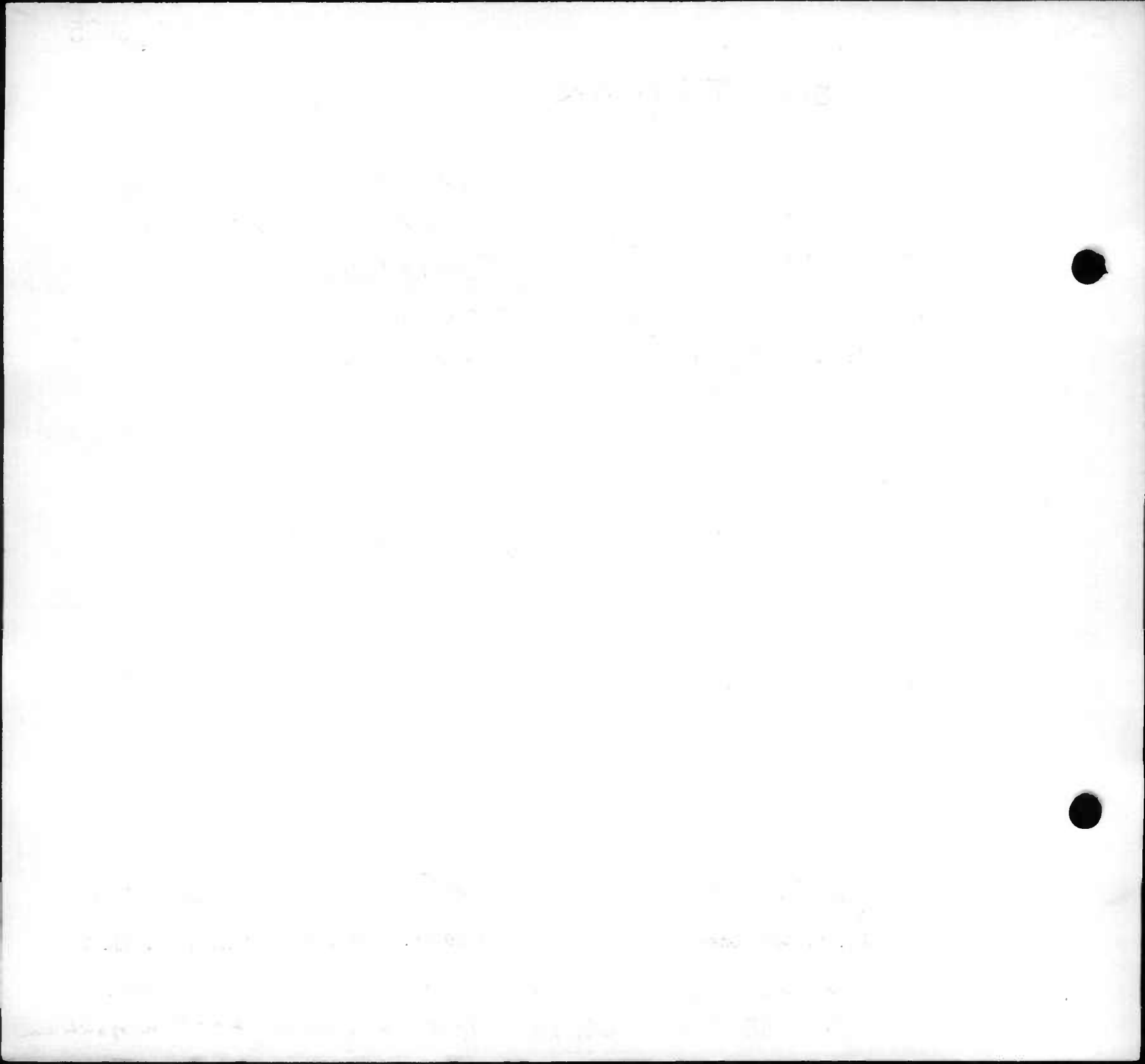
Joseph L. Russ Funeral Home

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460 1

72 Q6035		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 Q6035	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SIP TAYLOR		2. DATE AND HOUR OF DEATH 6/19/72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE md B. COUNTY 1607		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1028 Ellicott Dr					
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 12 1906	9. AGE (in years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Antwr		10B. KIND OF BUSINESS OR INDUSTRY State Rd Comm		11. BIRTHPLACE (State or foreign country) Ox Ford NC	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Charles Taylor		14. MOTHER'S MAIDEN NAME May			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT 1	
ADDRESS					
18. 322X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE convulsive seizure DUE TO, OR AS A CONSEQUENCE OF: (B) (old) brain abscess DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 06/16/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED brain abscess		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) lost saw the deceased alive on _____ 19 _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 6/22/72			
23C. PHYSICIAN'S NAME (Type) Dr. G. Lee Russo		23D. ADDRESS 1010 St. Paul Street Balto, Md. 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) B		24B. DATE 6/23/72		24C. NAME OF CEMETERY or CREMATORY Arbutus mem pk	
24D. LOCATION Balto Md					
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR P.R. E. Fabe Jr		25C. FUNERAL DIRECTOR Joseph E. Russo	
ADDRESS		2222 W North Ave			



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H-530

72 06036

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06036

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Denise Handy		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 6 10 72	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 10 72 2:45 a.	
6. SEX female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH July 16, 1937		10. AGE (In years lost birthday) 14	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Sykes		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1502	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Rosie Handy		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Mr Charles Sykes	
19. E 9 5 7 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) BRIDGE	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Edmondson St. Bridge (above 500 blk. of Ellicott Dr.)		22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY 6 10 72 approx 2:35 m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject jumped off a bridge.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/10/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jun 14, 1972	
24C. NAME of CEMETERY or CREMATORY Arbutus Men Park		24D. LOCATION (City, town, or county) (State) Arbutus Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR D. E. Fisher, Jr.	
25C. FUNERAL DIRECTOR Joseph G. Russo		ADDRESS 2222 W. North Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 06037

BIRTH NO. 72 06037

1. NAME OF DECEASED
(Type or Print)

JOHN B. JOY, SR.

2. DATE AND HOUR OF DEATH

6/26/72 4:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE MARYLAND B. COUNTY CARROLL

C. CITY OR TOWN
TANEYTOWN

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

RT 1 KUMP STATION ROAD

5. SEX

6. RACE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

MALE CAUCASIAN

WIDOWED ☐ DIVORCED ☐

4-2-12

60

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

HAULING CONTRACTOR (TRUCKING)

MARYLAND

U.S.A

13. FATHER'S NAME

THOMAS JOY

14. MOTHER'S MAIDEN NAME

ELIZABETH DEBILIUS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

YES

WW II

212-12-2774

MRS. JOHN B. JOY SR.

TANEYTOWN RT. 1 MD.

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

METABOLIC COMA 36 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) HEPATIC & RENAL FAILURE 3 weeks
DUE TO, OR AS A CONSEQUENCE OF:

(C) LAENNEC'S CIRRHOSIS MANY YEARS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

GI HEMORRHAGE

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

6/16/72

ESOP. VARICES

NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work ☐ Not While At Work ☐

22. I certify that (I) (this hospital) attended the deceased from 5/15 1972 to 6/26 1972 that (I) (we) last saw the deceased alive on 6/26 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Leslie Pearlstein MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/26/72

23C. PHYSICIAN'S NAME (Type)

LESLIE PEARLSTEIN MD

23D. ADDRESS

JOHNS HOPKINS HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

BURIAL

6-29-72

EVERGREEN MEM. GARDENS

FINKSBURG CARROLL CO. MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUN 29 1972

J. E. Taylor, Jr.

J. E. Taylor, Jr., Westminster, Md.

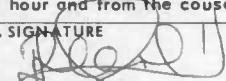
ELIZABETH T. COLLINS

YOL. 24. 17

THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 06038	
BIRTH NO. 72 06038				1. NAME OF DECEASED (Type or Print) BEACH, Charles Robert		2. DATE AND HOUR OF DEATH 6-26-72 11:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2808 Huntinton Avenue			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-99		9. AGE (In years last birthday) 73	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Janitor			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Robert Beach			14. MOTHER'S MAIDEN NAME Louise Johnson				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5-31-17 to 1-18			16. SOCIAL SECURITY NO. 218-09-1732		17. INFORMANT VA Hospital Records Baltimore, Maryland 21218		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ca of lung - ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cedexia -				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes XXXX		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that X (this hospital) attended the deceased from May 22, 1972 to June 26, 1972 , that X (we) last saw the deceased alive on June 26, 1972 and that in X (our) opinion death occurred on the date and hour and from the causes stated above, X (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED 6/28/72		23C. PHYSICIAN'S NAME (Type) RICARDO A COTTON	
23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218		23E. DATE REC'D BY HEALTH DEPT. JUN 29 1972					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/72		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. NAME OF REGISTRAR John A. Moran, Inc.		25B. FUNERAL DIRECTOR John A. Moran, Inc.		25C. ADDRESS 3000 E. Baltimore St. Baltimore, Md. 21224		25D. DATE 6/28/72	

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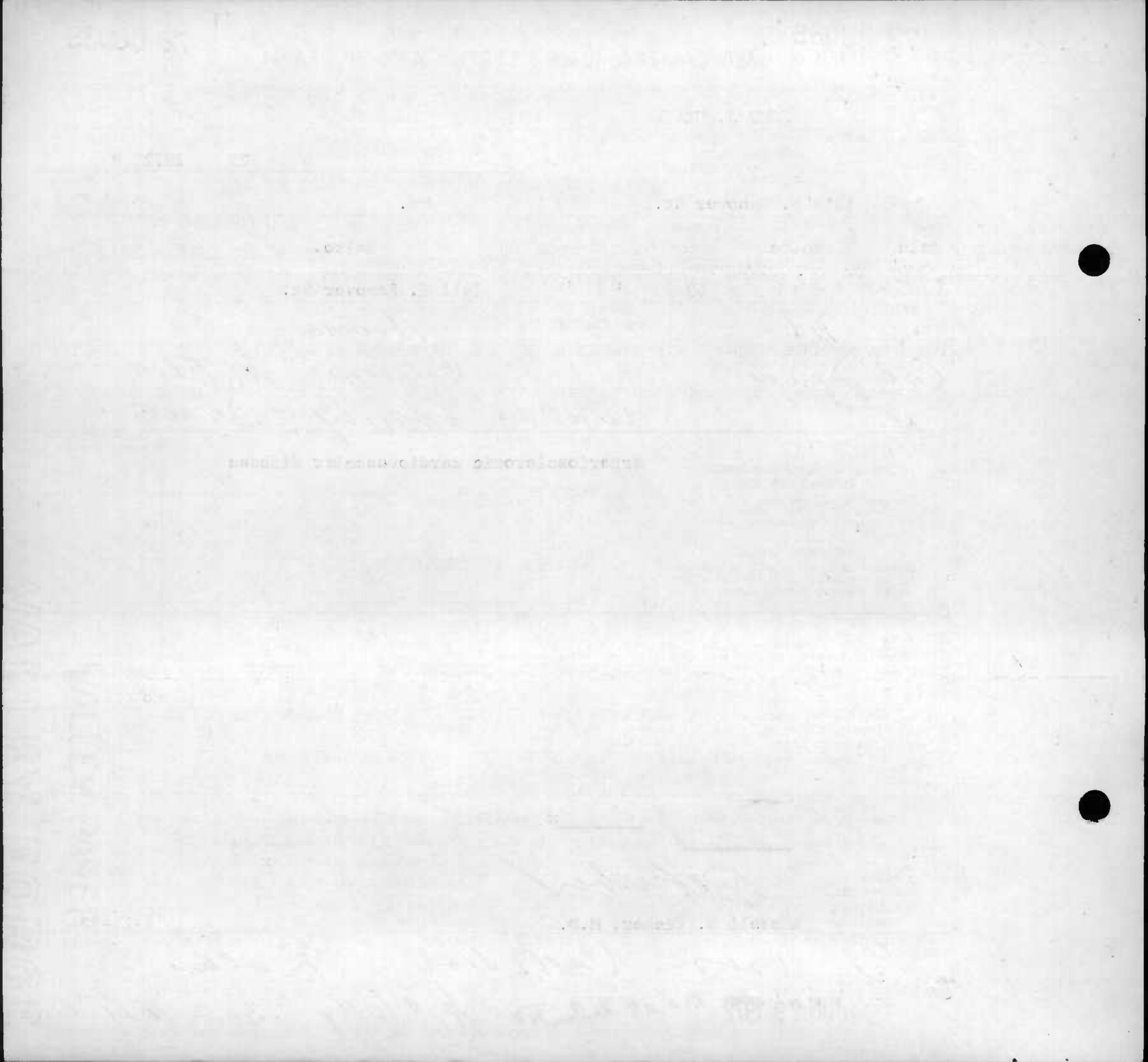
72 06039

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06039

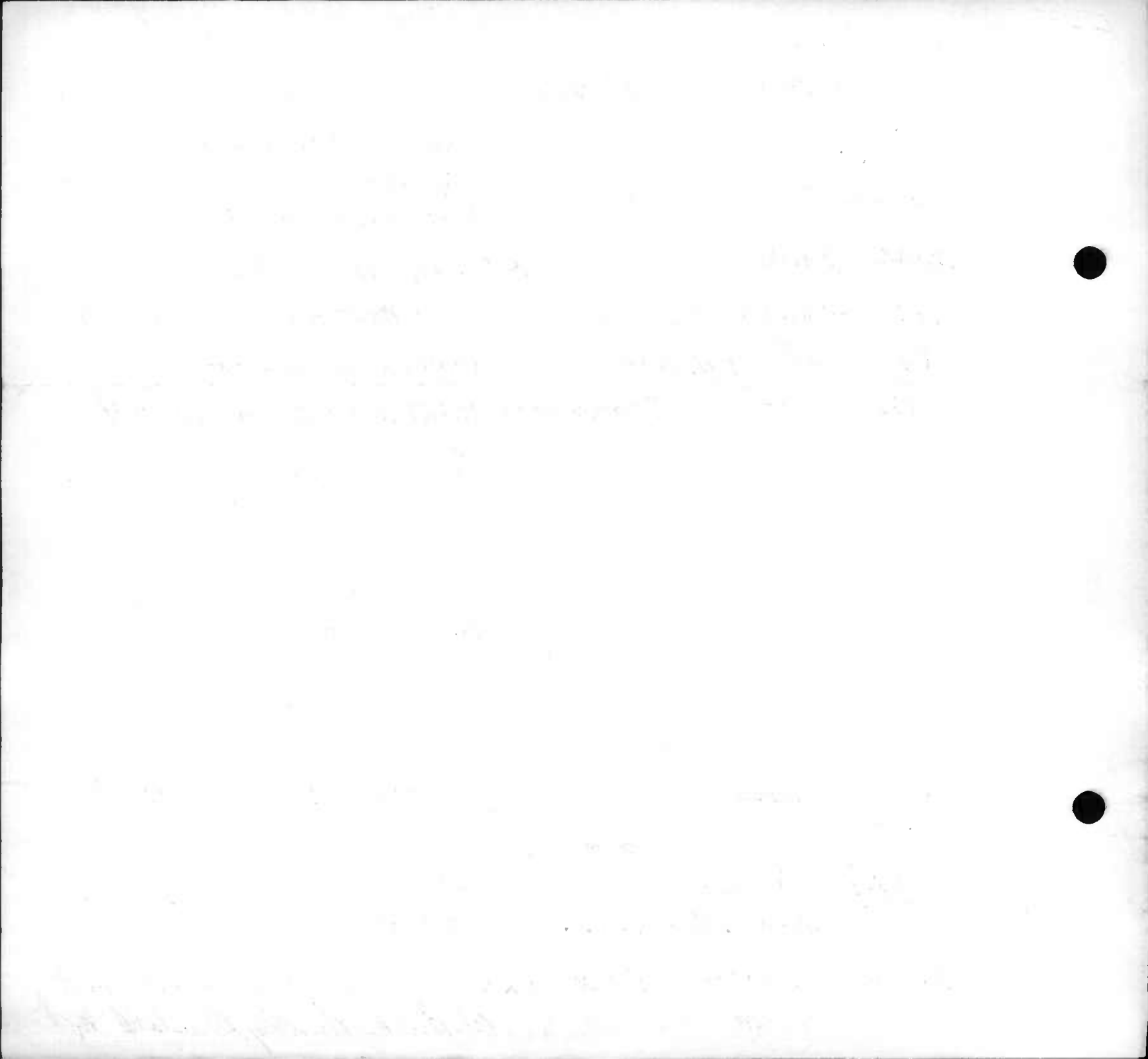
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) JOHN J. GRAIL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1411 S. Hanover St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 25 1972 8 p M.	
6. SEX male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE white		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2301	
9. DATE OF BIRTH 1-20-03		10. AGE (In years lost birthday) 69	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Catherine Mitchell		13. FATHER'S NAME Thomas	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 220-05-7615	
18. INFORMANT FAMILY - SAME		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 6-22-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-26-72			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-28-72	
24C. NAME OF CEMETERY or CREMATORY Cath. Church		24D. LOCATION (City, town, or county) (State) Balto.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR D. A. J. B. M.D.	
25C. FUNERAL DIRECTOR M. C. Kelly - 130 E. Fort Ave		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

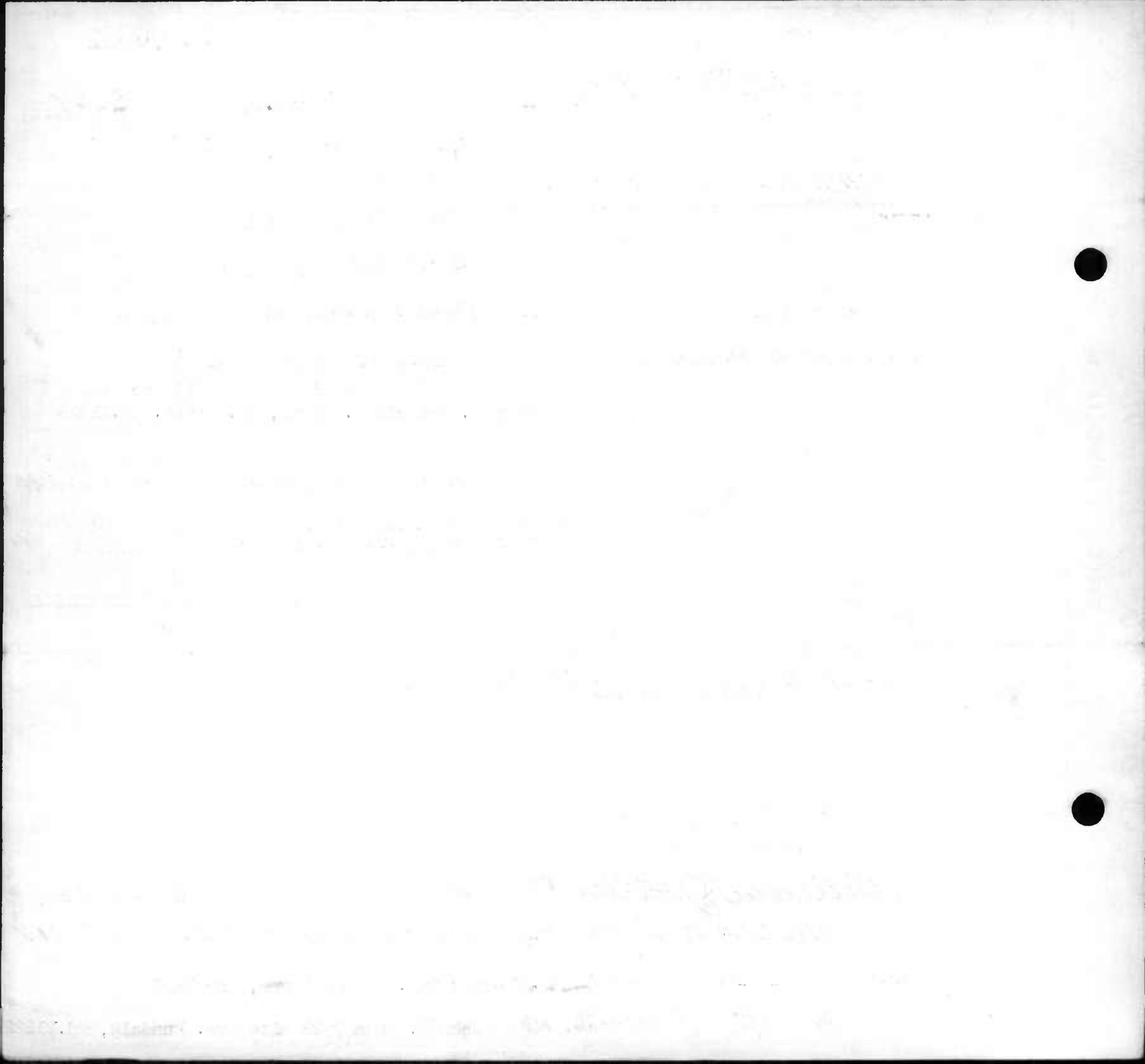
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-5501		72 06040		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06040	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		CARL FANNIN		6-25-72 9:50 P.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION GOULD CONVALESCARIUM				A. STATE Md		B. COUNTY BALTO. 21222 5300			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN DUNDALK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER 1221 HILLSHIRE Rd.					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH OCT. 26, 1899	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IRON WORKER		10B. KIND OF BUSINESS OR INDUSTRY CONSTR.		11. BIRTHPLACE (State or foreign country) OHIO KY.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DANIEL FANNIN				14. MOTHER'S MAIDEN NAME PRUDENCE LONG					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 278-05-0585		17. INFORMANT MART H. MAY - AS IN #4		ADDRESS			
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Due to, or as a consequence of: Admission of the lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. (known)			
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Emphysema Chronic Bronchitis									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from 7/21/71 to 6/27/72 that (I) (we) last saw the deceased alive on 6/27/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 6/27/72					
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.				23D. ADDRESS 4900 Belair Road 21206					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/28/72		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTIMORE CO. Md			
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR D. E. F. B.		25C. FUNERAL DIRECTOR W. Brooks Bradley, Dundalk, Md.		ADDRESS			



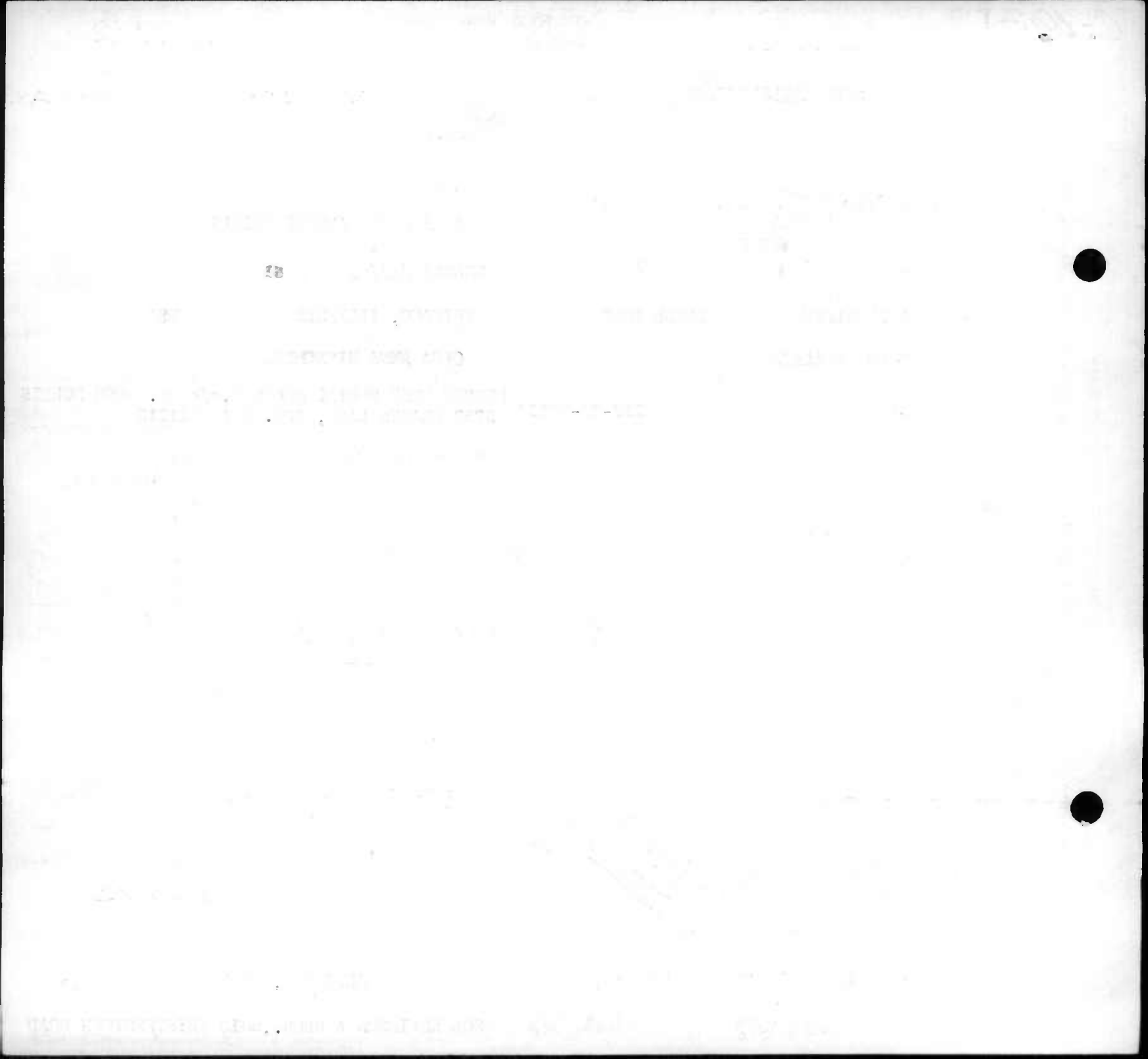
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-550		72 06041		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06041	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Elizabeth Ann Seman			
2. DATE AND HOUR OF DEATH 6-24-72 8:30 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE				C. CITY OR TOWN Edgemere			
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				E. STREET AND NUMBER 2511 PAC LANE			
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-39	
9. AGE (In years last birthday) 33 YRS		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10A. USUAL OCCUPATION		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES P. LOHR				14. MOTHER'S MAIDEN NAME ELSIE WEAVER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 197-30-7302		17. INFORMANT Husband: Mr. Francis M. Seman, Sr. Balto. Md. 21219	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: POST-PARTUM HEMORRHAGE (B) DUE TO UTERINE ATONY DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 6-24-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED POST-PARTUM HEMORRHAGE		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William J. Fetter				23B. DATE SIGNED 6-24-72			
23C. PHYSICIAN'S NAME (Type) WILLIAM J. FETTER				23D. ADDRESS 3101 ST. PAUL ST., BALTO., MD. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-72		24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR J. E. Fetter		25C. FUNERAL DIRECTOR ADDRESS John J. Duda 7922 Wise Ave. Dundalk, Md. 21222			



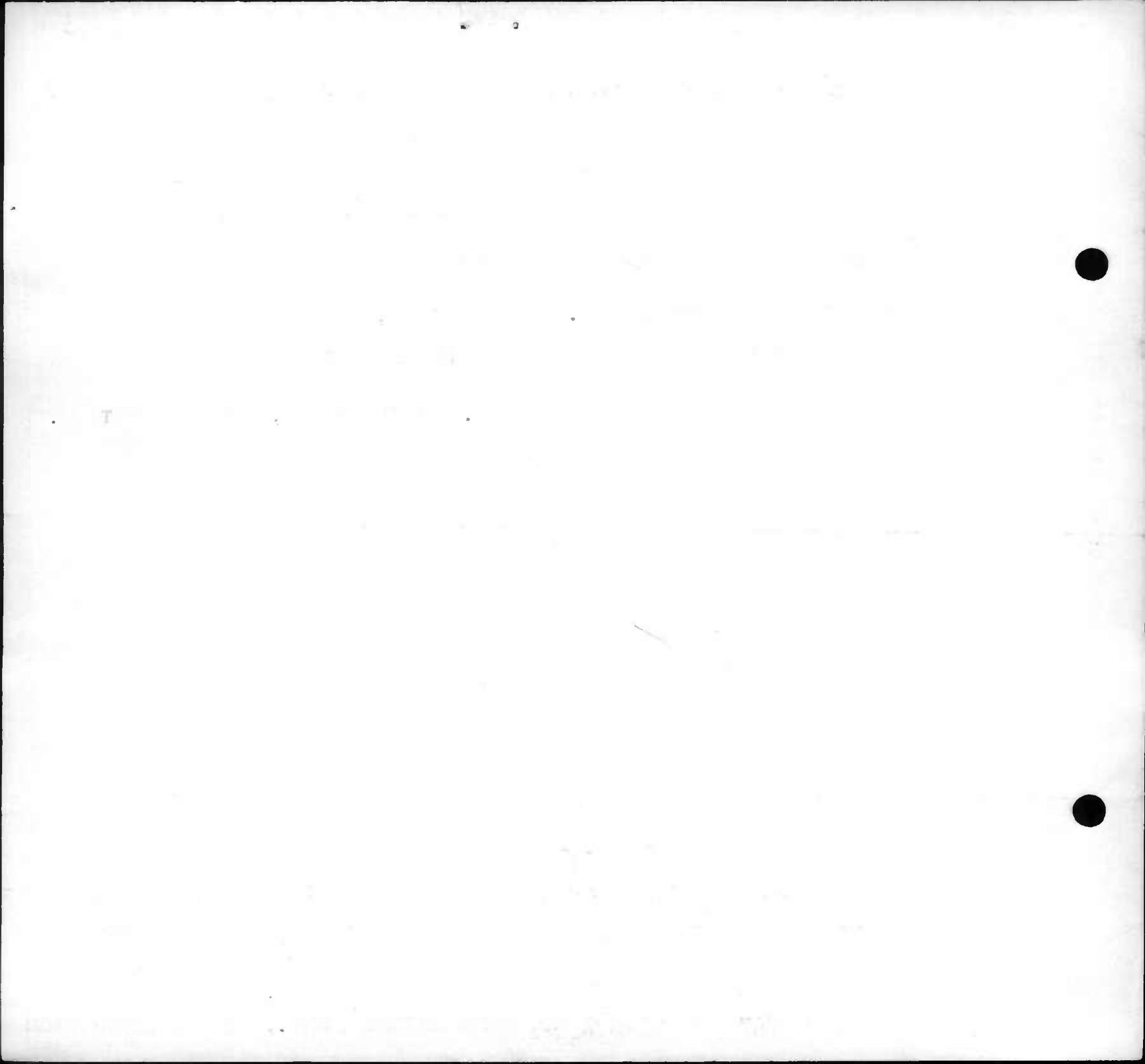
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-4621		72 06042		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06042	
BIRTH NO. 72 06042				1. NAME OF DECEASED (Type or Print) BESSYE DESSUE CLARK					
2. DATE AND HOUR OF DEATH JUNE 26, 1972 12:30 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL					
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2716 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4805 HOMER AVENUE #21215				5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH 10/10/1922 79				9. AGE (In years last birthday) 79		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS				10B. KIND OF BUSINESS OR INDUSTRY DRESS SHOP		11. BIRTHPLACE (State or foreign country) CHICAGO, ILLINOIS			
12. CITIZEN OF WHAT COUNTRY USA				13. FATHER'S NAME OSCAR GOLDMAN				14. MOTHER'S MAIDEN NAME OLGA ANNA HIRSCHBERG	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO				16. SOCIAL SECURITY NO. 215-22-5915A		17. INFORMANT ADDRESS HEBREW FREE BURIAL SOCIETY, c/o MR. MOSE MORRIS 3737 CLARKS LANE, APT. 101 #21215			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH INFECTED DECUBITUS ULCERS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MONTHS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. DATE OF OPERATION 2/27/72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from April 29 1970 to June 26 1972 that (H) (we) last saw the deceased alive on June 26 1972 and that (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (not) view the body after death.									
23A. SIGNATURE Theodore R. Reiff				23B. DATE SIGNED 6-26-72		23C. PHYSICIAN'S NAME (Type) THEODORE R. REIFF, M.D.			
23D. ADDRESS LEVINDALE									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 6/27/72		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972				25B. NAME OF REGISTRAR P. A. E. F. B. R. D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

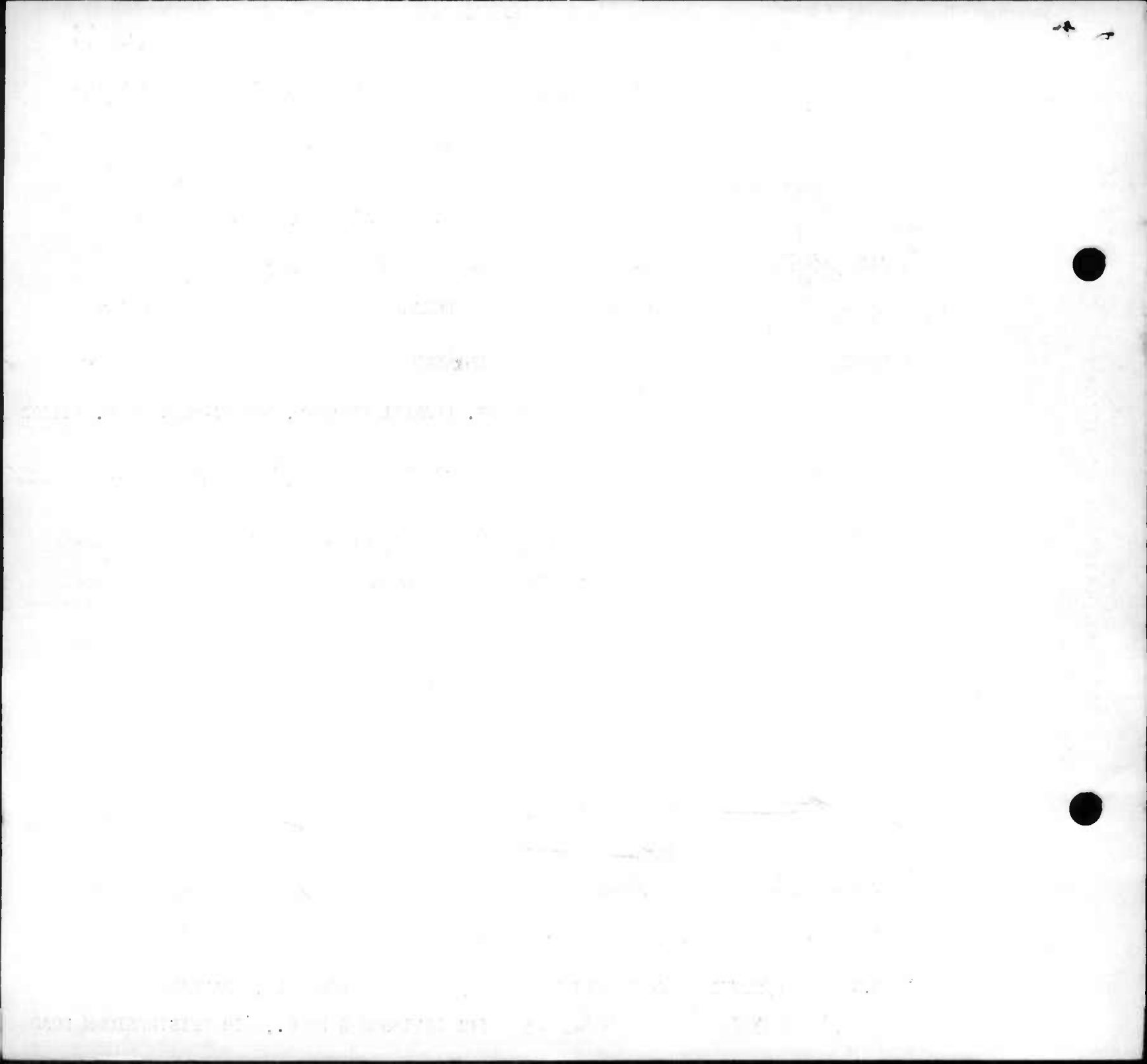
72 Q6043		BALTIMORE CITY HEALTH DEPARTMENT		72 Q6043	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Esther Schwartzman		2. DATE AND HOUR OF DEATH 6-25-72 2:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hosp. of Balt.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2730 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3307 BONNIE ROAD #21215			
5. SEX FEMALE	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/1904	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY INSURANCE CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME AARON BORENSTEIN			
14. MOTHER'S MAIDEN NAME RACHEL ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT MR. ALAN SCHWARTZMAN, 4713 BELLE FORTE RD. #8			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma to Brain ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Endometrial Carcinoma		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 6-18-72 1972 to 6-25 1972 that (I) (we) lost saw the deceased alive on 6-25 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Joshua Frankel		23B. DATE SIGNED 6-25-72		23C. PHYSICIAN'S NAME (Type) Joshua Frankel	
23D. ADDRESS Sinai Hosp of Balt		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 6/27/72		24C. NAME OF CEMETERY OR CREMATORY BETH TFILOH		24D. LOCATION BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Blue E. Faber, Jr.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

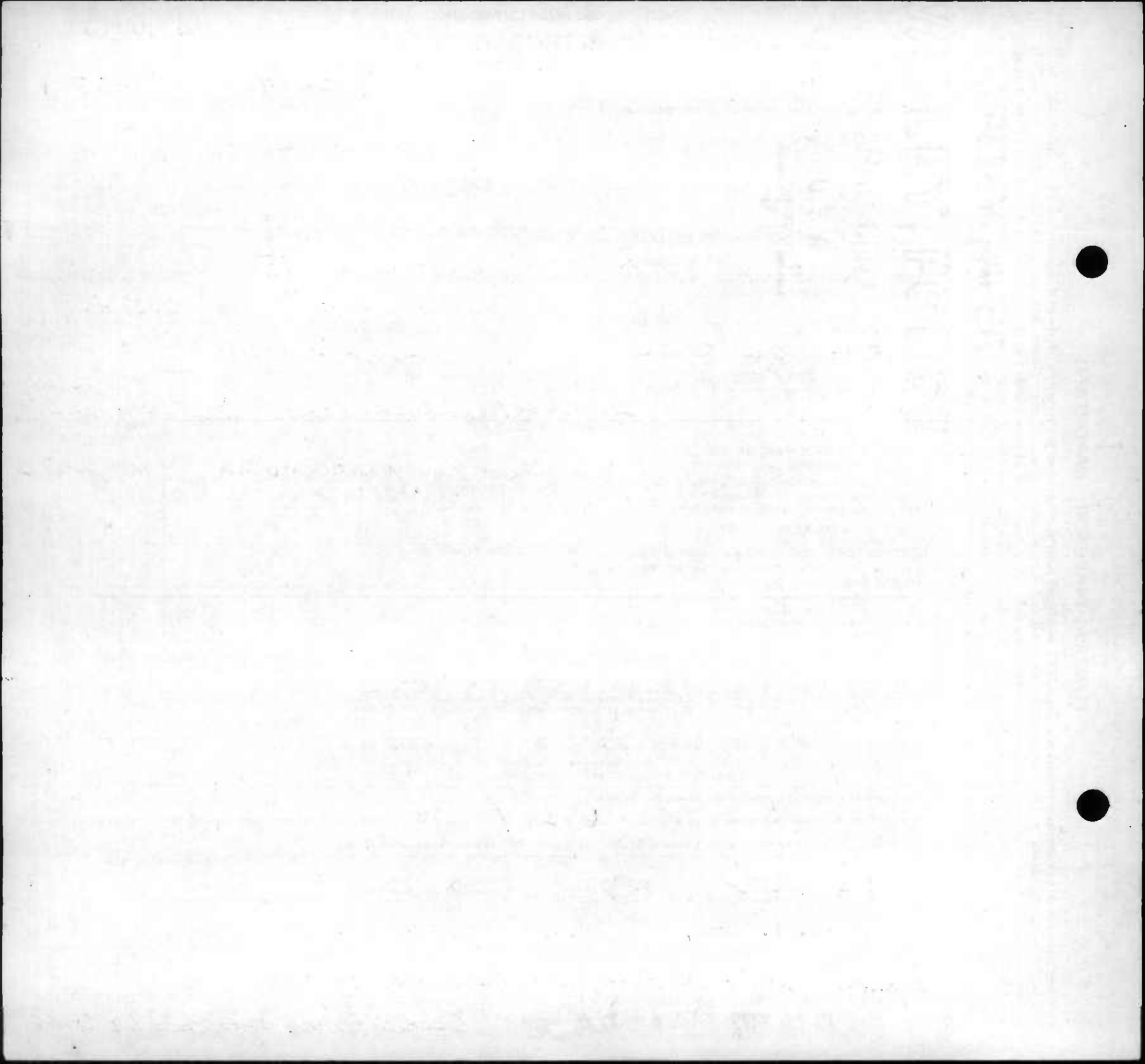
72 06044		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06044	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Joseph David Switzer</u>		2. DATE AND HOUR OF DEATH <u>6/25/72</u> <u>7⁰⁰ AM.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>M.D.</u> B. COUNTY <u>BALTIMORE CITY</u>		2841	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Univ. of Md. Hospital</u> 38		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3612 Ferndale Ave</u>			
5. SEX <u>MALE</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/88</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Made Plastic Bags</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>219-26-1663</u>		17. INFORMANT <u>MR. EMANUEL GORFINE, 900 GARRETT BLDG. #21202</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Myocardial Infarct.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypotension (Postural)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>BRADYCARDIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>1 yr.</u> <u>1 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that the (this hospital) attended the deceased from <u>JUNE 5, 1972</u> to <u>JUNE 25, 1972</u> that we (we) last saw the deceased alive on <u>JUNE 24, 1972</u> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.					
23A. SIGNATURE <u>C. Thomas Folkemer M.D.</u>		23B. DATE SIGNED <u>6/25/72</u>		23C. PHYSICIAN'S NAME (Type) <u>C. Thomas Folkemer M.D.</u>	
23D. ADDRESS <u>Univ. Hosp., Baltimore, Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>6/28/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ANSHE NEISEN</u>		24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1972</u>		25B. NAME OF REGISTRAR <u>SOL LEVINSON & BROS.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

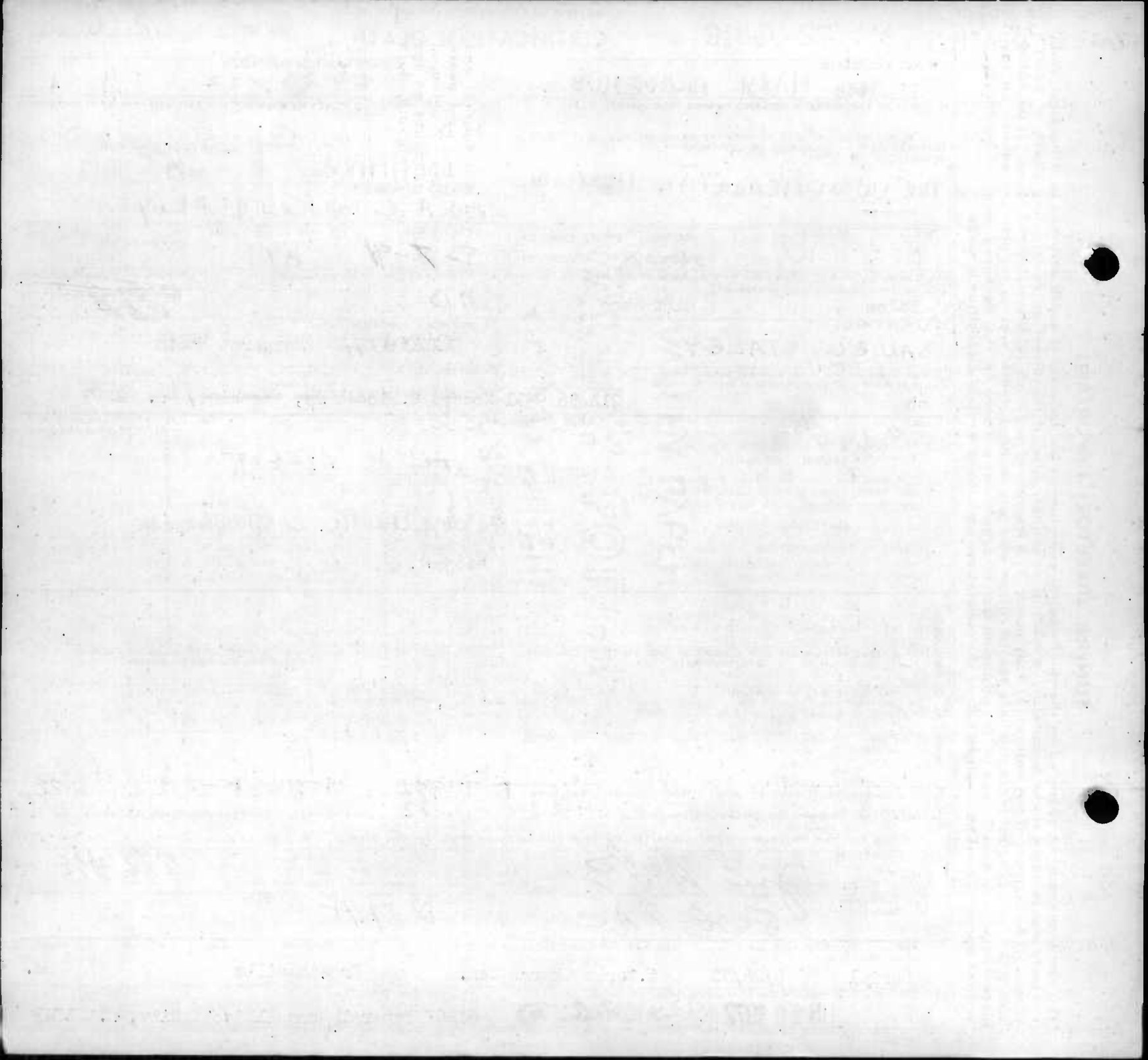
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 Q6045
BIRTH NO. 72 Q6045				
1. NAME OF DECEASED (Type or Print) ANNA B. DEMPSEY		2. DATE AND HOUR OF DEATH 6/26/72 11:55 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Good Samaritan Hospital 45		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 413 MURDOCK RD.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-96	9. AGE (In years lost birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME FLEETWOOD KOUTZ		
14. MOTHER'S MAIDEN NAME ANNA ALESSER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 215-03-P689		17. INFORMANT Mrs. M. LEONA EASTON, 938 DUCANEY VALLEY RD.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) adeno carcinoma of the colon		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH may 1972		
19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 6/26/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE I. A. Orer, M.D.				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) I. A. Orer, M.D.				23D. ADDRESS The Johns Hopkins Hospital
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 28 JUNE 72		24C. NAME OF CEMETERY or CREMATORY GREENMOUNT MAUSOLEUM
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD				
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR P. A. E. J. E. J.		25C. FUNERAL DIRECTOR CLERICH FUNERAL HOMES, BALTO, MD 21206



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06046		BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH		REG. NO. 72 06046	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elizabeth MARY NICODEMUS		2. DATE AND HOUR OF DEATH 6-23-72 3 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 1202			
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL 44		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 300 A.E. UNIVERSITY PKWY		5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-8-91 9. AGE (In years last birthday) 81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10B. KIND OF BUSINESS OR INDUSTRY Gift Shop		11. BIRTHPLACE (State or foreign country) MD 12. CITIZEN OF WHAT COUNTRY? English USA	
13. FATHER'S NAME DANIEL STALEY		14. MOTHER'S MAIDEN NAME BOOTH Margaret Booth			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214 36 9831		17. INFORMANT ADDRESS Howard C. Nicodemus, Woodbine, Md. 21797	
18. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST (B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLECTIC CARDIOVASCULAR DISEASE (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-10-72 19 72 to 6-23 19 72, that (I) (we) last saw the deceased alive on 6-23 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joe A. Pal		23B. DATE SIGNED 6/23/72			
23C. PHYSICIAN'S NAME (Type) JOSE PAL		23D. ADDRESS 17 H			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6/26/72		24C. NAME OF CEMETERY OR CREMATORY St. Marks Church Cem.	
24D. LOCATION Breathsville		(City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR R. E. Fisher, MD		25C. FUNERAL DIRECTOR SLACK Funeral Home Ellicott City, Md. 21043	



1
T-524

72 06047

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 06047

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES R. TANZELLA

2. DATE
OF
DEATH

Known ☐ Estimated ☐

Month Day Year Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 Rear of 1726 Brady St.

3. DATE
PRONOUNCED DEAD

Month Day Year Hour

6 26 1972 7:34 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

1102

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Nov 29 1944

10. AGE (In years last birthday)

late 20's

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

27

E. STREET AND NUMBER

4 4th Ave Lansdowne Md.
St. Paul & Preston Sts.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

Michael Tanzella

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Cab Driver

15. MOTHER'S MAIDEN NAME

Thelma Tanzella

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Army

Vietnam

17. SOCIAL SECURITY NO.

212 44 8790

18. INFORMANT

ADDRESS

Michael Tanzella 4 4th Ave Lansdowne Md.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Asphyxia

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) submersion of face in mud after impact to head

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

rear of 1726 Brady St.

22D. TIME OF INJURY (APPROX.)

6-26-72

(Month) (Day) (Year) (Hour)

a

22E. INJURY OCCURRED

WHILE AT WORK ☒

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

Subject beaten.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-26-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/30/72

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State)

Belair Road Balto Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 29 1972

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

McCully Funeral Home 237 Tatapasco Ave

ADDRESS

Med Exam. gives address as
St. Paul & Preston Sts.

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BIRTH NO. 72 06048				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06048	
1. NAME OF DECEASED (Type or Print) STURM, CLARENCE WHEELER				2. DATE AND HOUR OF DEATH JUNE 25, 1972 6:40 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 21228			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 200 PRESTON COURT				5300			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05 15 00	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY WHITE SERV. SALES		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM ANTHONY STURM				14. MOTHER'S MAIDEN NAME ELIZABETH KNAUSE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215015089		17. INFORMANT BALTIMORE, MD. 21229 ADDRESS ST AGNES' RECORDS-CATON & WILKENS AVE.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH Suspected Pulmonary Embolism IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 16, 1972 to JUNE 25, 1972, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 25, 1972 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE San Pedro, S, MD				23B. DATE SIGNED 06/25/72		23C. PHYSICIAN'S NAME (Type) SAN PEDRO, S, MD	
23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVE				23E. FUNERAL DIRECTOR Barley Cavanaugh		23F. ADDRESS FURNERAL HOME	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-72		24C. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR P. R. E. Faber		25C. FUNERAL DIRECTOR Barley Cavanaugh		25D. ADDRESS FURNERAL HOME	

RECEIVED FOR THE DIRECTOR

1948

6:40 A.

JUNE 22, 1975

STATION, CLARENCE WHEELER

11:22

MATTHEW B. BALLYMORE

15 X

300 FREEDOM STREET

ST. ANNE'S HOSPITAL
CATHOLIC WILLIAMS AVENUE
BALTIMORE, MARYLAND 21229

02 12 00

MALE CATHOLIC

U. S. A.

WHITE SERV. SALES MARYLAND

SALESMAN

ELIZABETH WARRICK

WILLIAM ANTHONY STUBBS

BALTIMORE, MD. 21229

ST. ANNE'S HOSPITAL, RECORDS-CATHOLIC & WILLIAMS AVE

MS

JUNE 22, 1975

JUNE 19

JUNE 22

XX

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66/22/75

BALTIMORE 21229

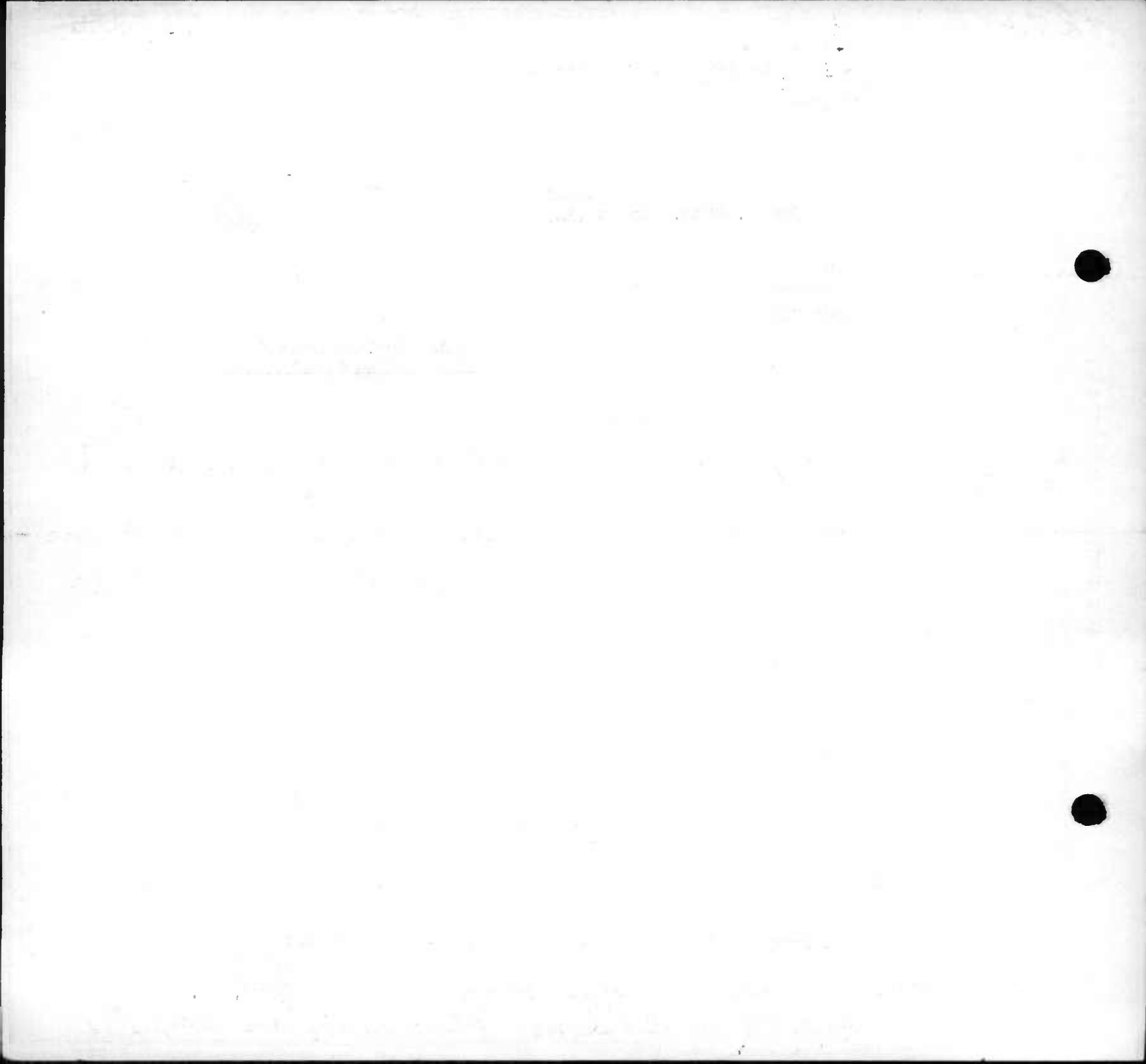
ST. ANNE'S HOSPITAL, CATHOLIC & WILLIAMS AVE

SAN PEDRO, 21 MO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 06049		72 06049	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Joyner Anna Nichols</u>				2. DATE AND HOUR OF DEATH <u>6-22-72</u> <u>1</u> <u>3:50</u> <u>P.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 Keswick</u> <u>21211</u> <u>700 W. 40th. Street (121X)</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1200 McRed The Ford Road 5300</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-79</u>	9. AGE (in years last birthday) <u>93</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Anne County Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Wilson B Nichols</u>			14. MOTHER'S MAIDEN NAME <u>Alice Virginia Arnold</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>218-69-8599</u>			17. INFORMANT <u>Keswick Records 700 W. 40th St.</u>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Nephrosclerosis with Uremia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis</u> <u>Diabetes mellitus</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>3 yrs</u> <u>4 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>18 Dec</u> 19 <u>69</u> to <u>22 June</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>22 June</u> 19 <u>72</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Aubrey D. Richardson</u>				23B. DATE SIGNED <u>22 June 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>Aubrey D. Richardson, M.D.</u>	
23D. ADDRESS <u>700 W. 40th Street</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/24/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fabe, Jr.</u>		25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld</u>		25D. ADDRESS <u>6500 York Rd</u>	

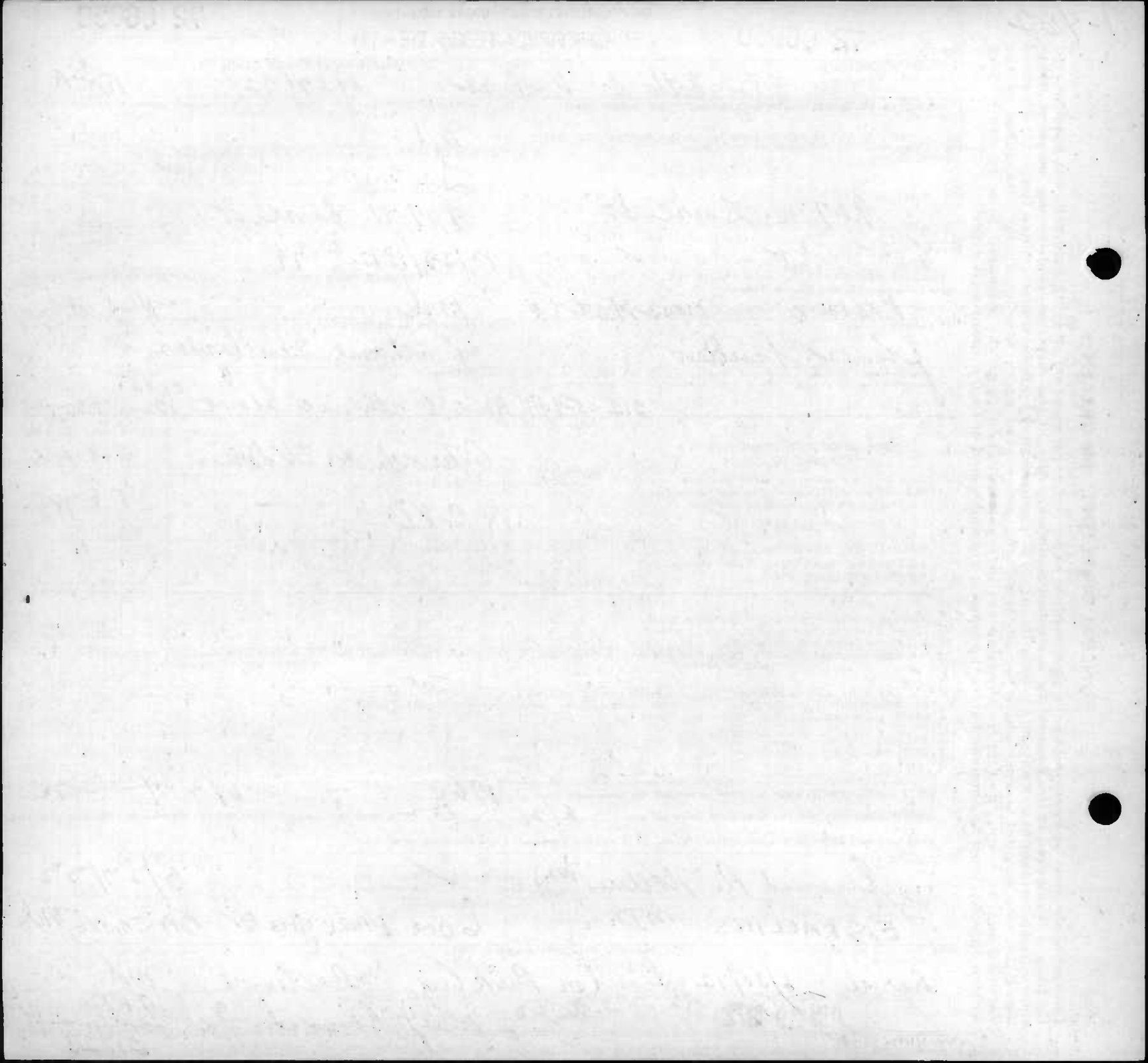


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 Q6050

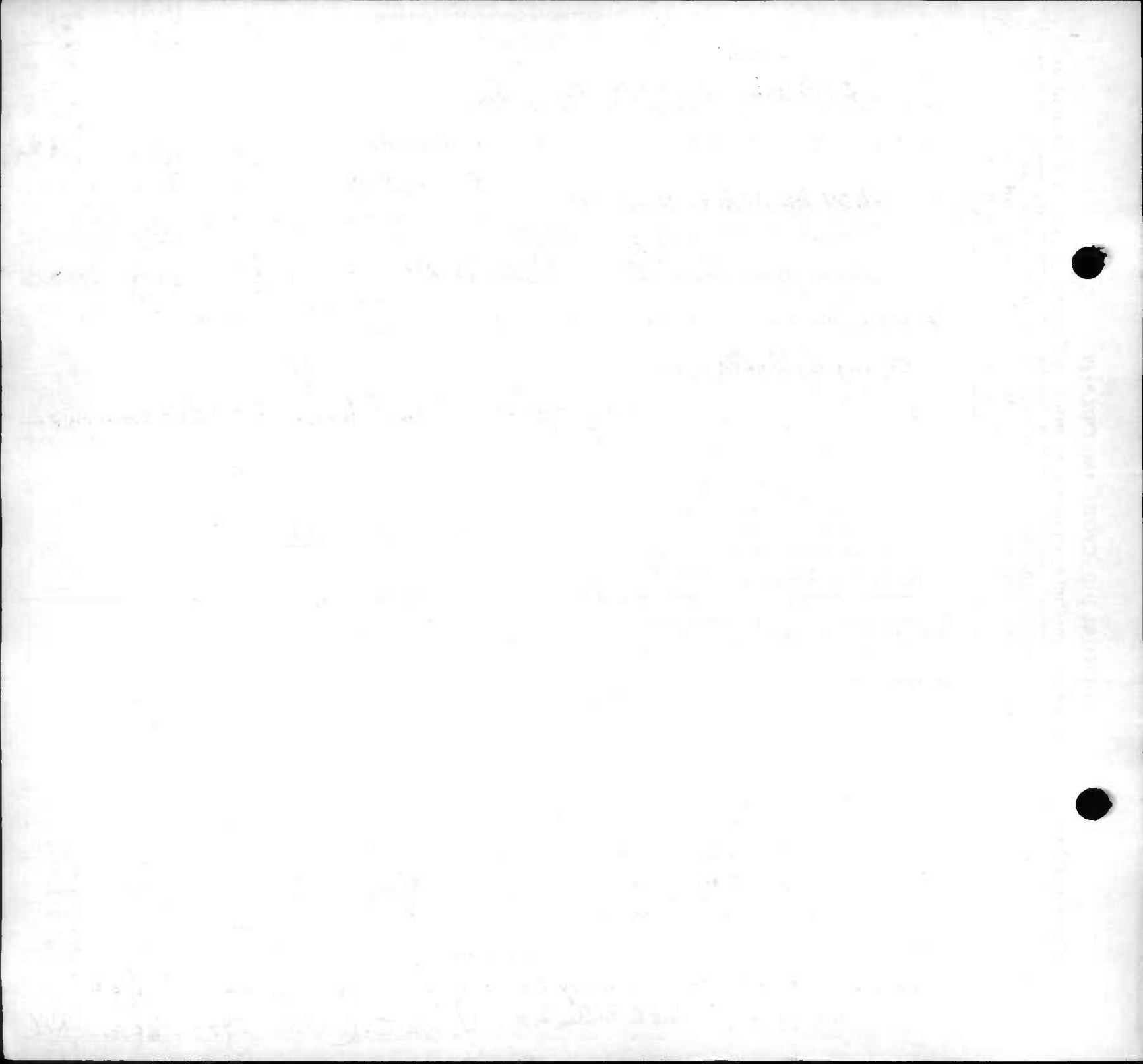
BIRTH NO. 72 Q6050		1. NAME OF DECEASED (Type or Print) <i>Elizabeth E. Vollers</i>		2. DATE AND HOUR OF DEATH <i>6/27/72</i> <i>10³⁰A</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>2101</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>907 W. Barre St.</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>12/19/1892</i>		9. AGE (In years last birthday) <i>79</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Presser</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>James Scullen</i>	
14. MOTHER'S MAIDEN NAME <i>Catherine Gallagher</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-05-9496</i>	
17. INFORMANT <i>Mrs Catherine Howe</i>		ADDRESS <i>2823 Drimmonds Ave</i>		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Arteriosclerotic CV Disease</i>	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>N CVD</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5-8 yrs</i>	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		<i>5-8 yrs</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1960</i> to <i>6/27/72</i> that (I) (we) last saw the deceased alive on <i>6/20</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Edward A. Hallins</i> M.D. DEGREE				23B. DATE SIGNED <i>6/27/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. S. KALLINS M.D.</i> DEGREE				23D. ADDRESS <i>6000 PARK HTS DR BALTIMORE MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/30/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Landon Park Cem</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. (State) <i>md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 29 1972</i>		25B. NAME OF REGISTRAR <i>J. E. Talley, MD</i>		25C. FUNERAL DIRECTOR <i>John J. Conner & Son Inc.</i> ADDRESS <i>907 W. Barre St. 21223</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 06051	
BIRTH NO. 72 06051		1. NAME OF DECEASED (Type or Print) BROOKS HARRY E., Jr		2. DATE AND HOUR OF DEATH 6-27-72 4:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5315 REMMELL AVE. 21206			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-98		9. AGE (In years last birthday) 73	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CASHIER		10B. KIND OF BUSINESS OR INDUSTRY RACE TRACKS		11. BIRTHPLACE (State or foreign country) MARYLAND DELAWARE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY E. BROOKS, SR				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) ?		16. SOCIAL SECURITY NO. 186-05-8655		17. INFORMANT MR. JOHN J. KERN		ADDRESS 6414 EVERALL AVE	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute RENAL FAILURE.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DEHYDRATION. ASCVD DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cirrosis of Liver - ALCOHOLISM							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Involves medical examination)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-7-1972 to 6-27-1972 that (I) (we) last saw the deceased alive on 6-27-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Julio A. Dejo M.D.				23B. DATE SIGNED 6-27-72			
23C. PHYSICIAN'S NAME (Type) Julio A. Dejo M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREATION, REMOVAL (Specify) BURIAL		24B. DATE 6-28-72		24C. NAME OF CEMETERY LOMBARDY CEMETERY		24D. LOCATION (City, town, or county) (State) WILMINGTON DEL	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Julio A. Dejo M.D.		25C. FUNERAL DIRECTOR J. Statten Conklin ADDRESS 5444 BELAIR RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. 72 06052		CERTIFICATE OF DEATH		REG. NO. 72 06052	
1. NAME OF DECEASED (Type or Print) VOLKERT, ETHEL ANNA				2. DATE AND HOUR OF DEATH JUNE 27 1972 2:30PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. 8. COUNTY ANNE ARUNDEL CO. C. CITY OR TOWN GLEN BURNIE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 700 N BROADVIEW BLVD. GARLAND GLEN			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 17 1900	9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME WILLIAM RENDALL				14. MOTHER'S MAIDEN NAME ELIZABETH (BROCK)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT WILKENS & CATON AVE. ST AGNES HOSPITAL RECORDS		ADDRESS	
18. 4/2/31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Renal Insufficiency Secondary to severe Nephrosclerosis Severe Coronary Artery Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 24 19 72 to JUNE 27 19 72 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 27 19 72 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) did not view the body after death.							
23A. SIGNATURE M. YOUSUF SIDDIQUI				23B. DATE SIGNED 6/27/72			
23C. PHYSICIAN'S NAME (Type) M. YOUSUF SIDDIQUI, M.D.				23D. ADDRESS BALTIMORE MARYLAND 12229 ST AGNES HOSPITAL CATON & WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/72		24C. NAME OF CEMETERY OR CREMATORY London Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Singleton Funeral Home		ADDRESS Glen Burnie, Md.	

1. 1000

JUNE 22 1902

WILLIAM BENTLEY

WILLIAM BENTLEY

WILLIAM BENTLEY

ST. ANNE'S HOSPITAL

JULY 17 1902

WILLIAM BENTLEY

WILLIAM BENTLEY

WILLIAM BENTLEY

WILLIAM BENTLEY

WILLIAM BENTLEY

WILLIAM BENTLEY

WILLIAM BENTLEY

WILLIAM BENTLEY

JUNE 22

JUNE 22

WILLIAM BENTLEY

WILLIAM BENTLEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06053	
BIRTH NO. 72 06053				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HADLEY, JAMES ADDISON			2. DATE AND HOUR OF DEATH JUNE 27, 1972 5:25A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 21227 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 4710 WASHINGTON BLVD. 5300		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05 21 17	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TECHNICIAN		10B. KIND OF BUSINESS OR INDUSTRY TELEVISION		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS	
13. FATHER'S NAME JAMES HADLEY			14. MOTHER'S MAIDEN NAME HELEN WOODBURY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW2		16. SOCIAL SECURITY NO. 077074004		17. INFORMANT ADDRESS RECORDS OF ST. AGNES HOSPITAL	
18. 21231 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			CAUSE OF DEATH Lung Tumor (Mesothelioma) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 24 19 72 to JUNE 27 19 72 , that (X) (we) last saw the deceased alive on JUNE 27 19 72 and that in (Xy) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.					
23A. SIGNATURE A. Alonso M.D. DEGREE			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 06 27 72
23C. PHYSICIAN'S NAME (Type) A. ALONSO M.D. DEGREE			23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVE. BALTO., MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/72		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery, Dorsey, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS Ambrose Inc. 1324 Sulphur Sp. Rd.	

2:55

JUNE 27, 1957

ROBERT, JAMES HOSPITAL

2:55

BALTIMORE

MARYLAND

ST. JAMES HOSPITAL

4710 WASHINGTON BLVD.

X

CAUSATION

MALE

02 21 17

22

TELEVISION

TECHNICIAN

MASSACHUSETTS

U.S.A.

WILSON WOODBURY

JAMES HOLEY

RECORDS OF ST. JAMES HOSPITAL

ADMISSION

AGE

SEX

NO

JUNE 27, 1957

JUNE 27, 1957

JUNE 27, 1957

XXX

ST. JAMES HOSPITAL

4710 WASHINGTON BLVD.

A. ALDRIDGE

1
L-125

72 06054

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 06054

BIRTH NO.

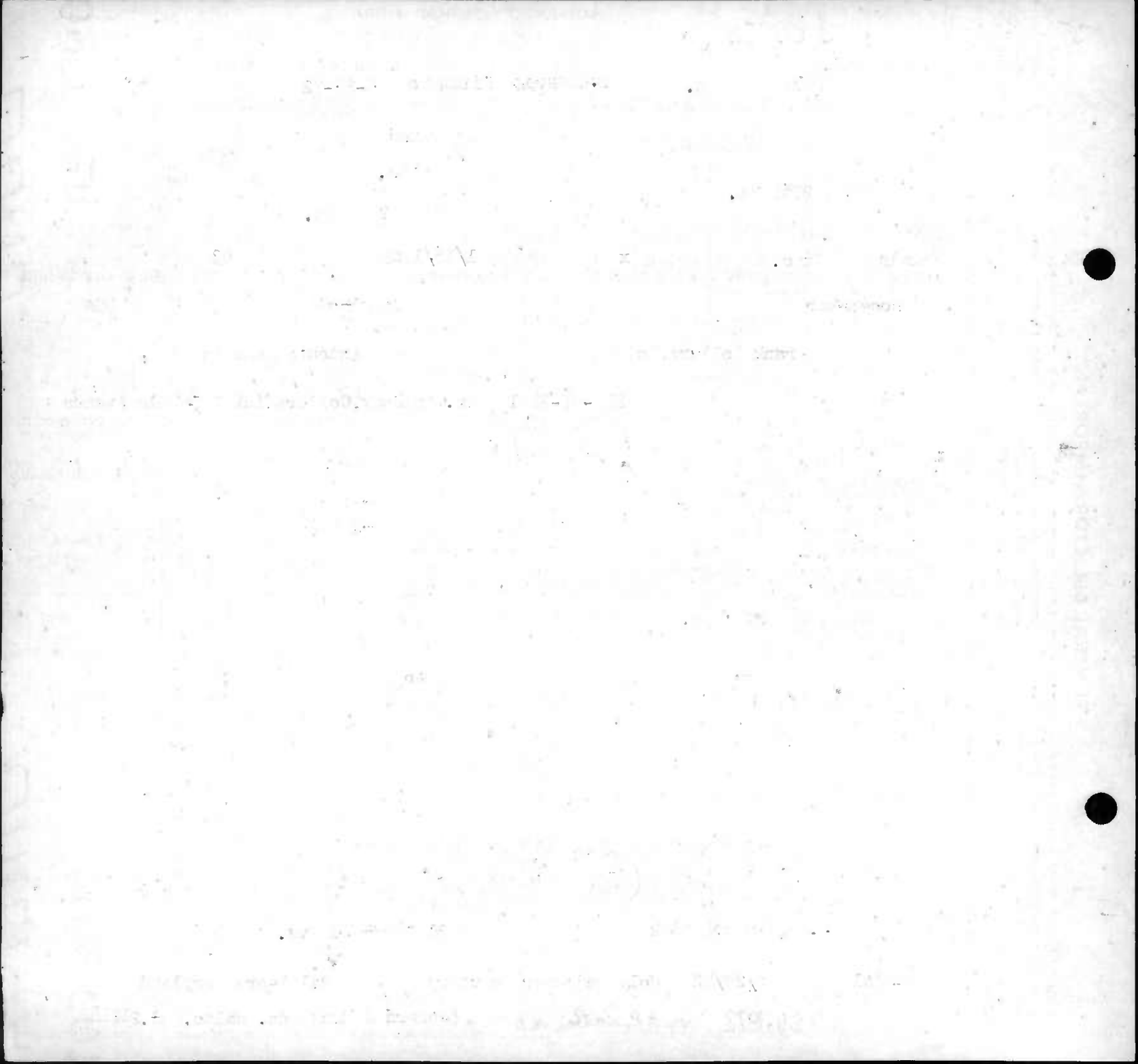
1. NAME OF DECEASED (Type or Print) GARY LIPSCOMB		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 SOUTH BALTO. GENERAL HOSPITAL 8-3-72		3. DATE PRONOUNCED DEAD Month Day Year Hour June 26, 1972 9:57 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3-4-49		10. AGE (In years last birthday) 23 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Malvin		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2302	
15. MOTHER'S MAIDEN NAME Malvin		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 219-35-6798		18. INFORMANT FAMILY NAME	
19. CAUSE OF DEATH 2985X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of abdomen ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bedroom	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 135 Ostend Street		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 6-26-72 5:40 P. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Self-inflicted Gunshot wound of abdomen	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/27/72			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-30-72	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR McCully - 130 E. Fort St.		ADDRESS	

8-3-1972 - Letter from the Office of the Chief Medical Examiner,
Ronald N. Kornblum, M.D., Deputy Chief Medical Examiner. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

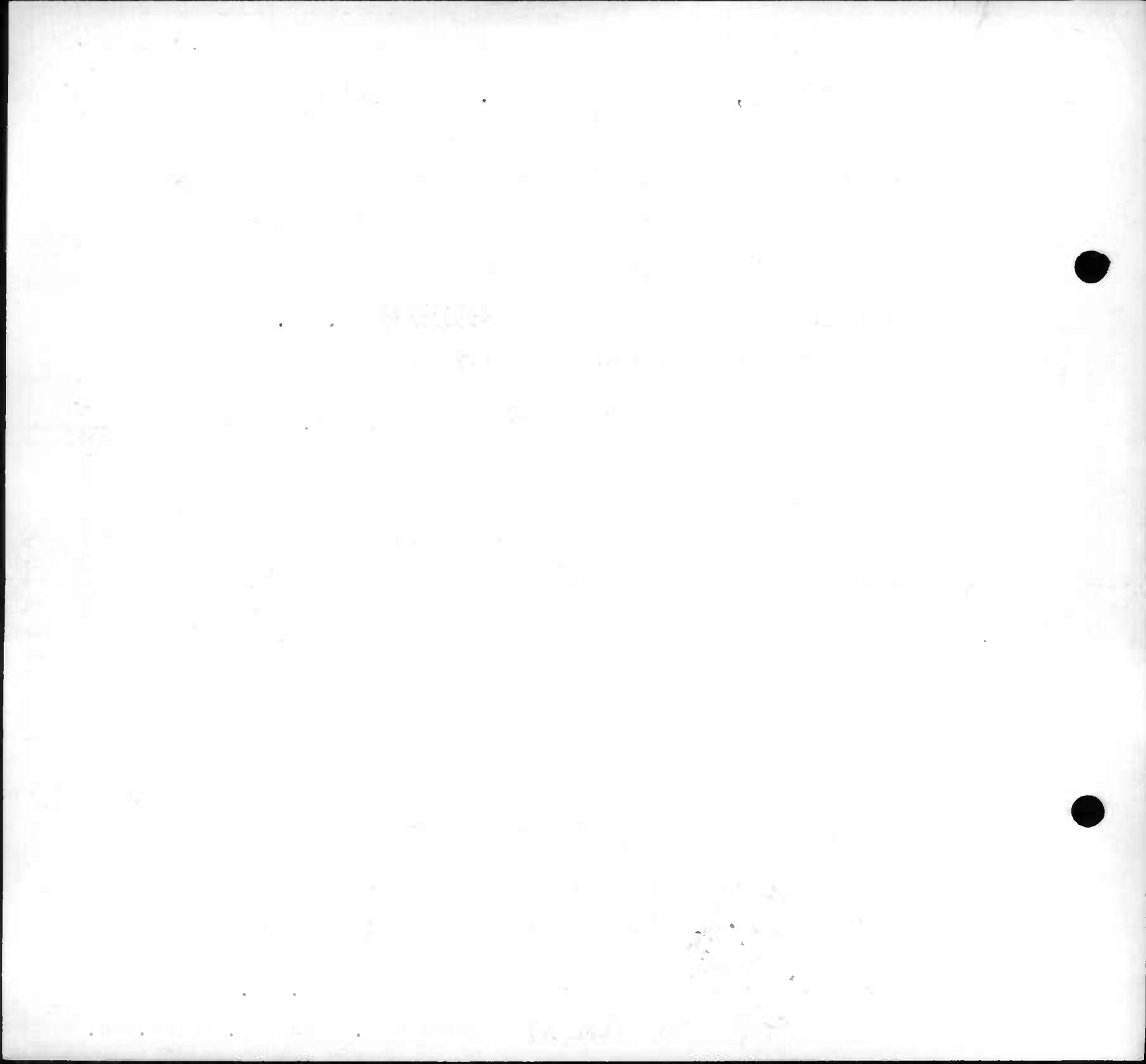
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. 72 06055					REG. NO. 72 06055				
1. NAME OF DECEASED (Type or Print) Grace M. XXXXXX Fiumara					2. DATE AND HOUR OF DEATH 6-25-72 8 A. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 315 E 27th St.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 315 E 27th St.				
5. SEX Female	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/16/1909	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frank Collurafici					14. MOTHER'S MAIDEN NAME Antonia Annello				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-07-3481		17. INFORMANT ADDRESS Mr. Anthony Collurafici 3708 Elm Avenue				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0					CAUSE OF DEATH Metastatic Carcinoma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma Breast (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several months one year				
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 6-22-1972 to 6-25-1972, that (I) (we) last saw the deceased alive on 6-22-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E. Ellsworth Cook MD DEGREE					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 6-26-72	
23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook DEGREE					23D. ADDRESS 2431 Maryland Ave.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Fabel, RD			25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Balto. Md.			ADDRESS 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06056		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06056	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MOUSE, Georgia A.</u>		2. DATE AND HOUR OF DEATH <u>6/26/72</u> <u>545 p</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2735</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Windsor Nursing Home</u> <u>3025 Windsor Ave</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3209 Glendale Ave.</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/90</u>	9. AGE (In years last birthday) <u>82</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>XXXXXXX W. Va.</u>	
13. FATHER'S NAME <u>Unknown Zollner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-54-3268 J1</u>		17. INFORMANT <u>George V. Mouse</u>	
18. <u>4124 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>ASCVD</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Malnutrition</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Severe Rheumatoid arthritis & deformity</u> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-17-1970</u> to <u>6-26-1972</u> that (I) (we) last saw the deceased alive on <u>6-23-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. I. Baykaler, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6-26-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. I. BAYKALER, M.D.</u>		23D. ADDRESS <u>301 Mc Mechen St. Balto.</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/29/72</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-5631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 06057

BIRTH NO.

72 06057

1. NAME OF DECEASED
(Type or Print)

LEONARD Ethel

2. DATE AND HOUR OF DEATH

6-25-72 4:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

North CHARLES Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE 8. COUNTY

MARYLAND

C. CITY OR TOWN

BALTO

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

E. STREET AND NUMBER

1224 W. 3rd St

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-1-1900

9. AGE (in years last birthday)

72

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Wm. E. Hooper Co.

10B. KIND OF BUSINESS OR INDUSTRY

Textile

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

213-05-0591

17. INFORMANT

WM. LEONARD (SAME)

ADDRESS

18.

4109 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute Myocardial Infarction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Acute

(B) CORONARY ARTERY DISEASE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary Artery Disease

yes

(C) ASCVD

yes

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-21-1972 to 6-25-1972 that (I) (we) last saw the deceased alive on 6-25-1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

KUPERTO MANANKIL MD

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

23D. ADDRESS

North Charles Gen. Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

6/28/72

24C. NAME OF CEMETERY OR CREMATORY

CORRAINE

24D. LOCATION (City, town, or county) (State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

JUN 29 1972

25B. NAME OF REGISTRAR

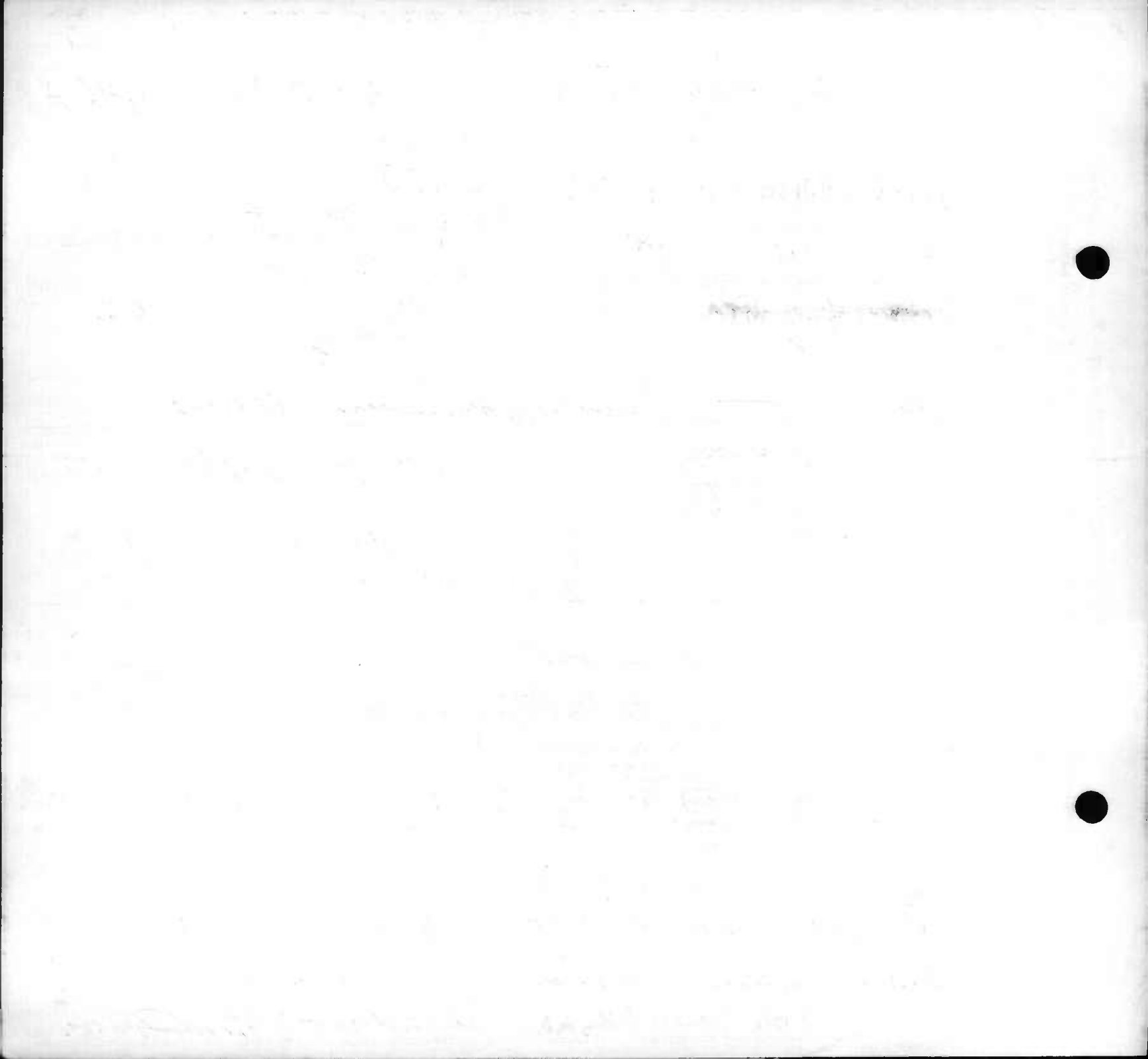
Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

Paul E. Raymond, MD

ADDRESS

3617 Chestnut Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F. 5201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 06058

BIRTH NO.

72 06058

1. NAME OF DECEASED
(Type or Print)

FENWICK, THOMAS VINCENT SR.

2. DATE AND HOUR OF DEATH

6/24/72

6:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md

St Mary's

C. CITY OR TOWN

CHAPTICO

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

GENERAL DELIVERY

5. SEX

M

6. RACE

N

7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8/14/18

9. AGE (in years last birthday)
53

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James T. Fenwick

14. MOTHER'S MAIDEN NAME

Louise Miles

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

214-28-4653

17. INFORMANT

Bernerdine Fenwick

ADDRESS

Chaptico, Maryland

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
Left Heart Failure

DUE TO OR AS A CONSEQUENCE OF:

(B) Perforated Esophagus

DUE TO OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 days

2 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

6/21/1972

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

PERFORATED DISTAL ESOPHAGUS

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month (Day) (Year) (Hour) (Approx.))

21E. INJURY OCCURRED

White At Work ☐

Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 21 1972 to June 24 1972 that (I) (we) last saw the deceased alive on June 24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

AGUSTIN H. FLORIAN, M.D.

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/24/72

23C. PHYSICIAN'S NAME (Type)

AGUSTIN H. FLORIAN, M.D.

DEGREE

23D. ADDRESS

UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/27/72

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart Cemetery

24D. LOCATION

(City, town, or county)

(State)

Bushwood, St Mary's, Maryland

25A. DATE REC'D BY HEALTH DEPT.

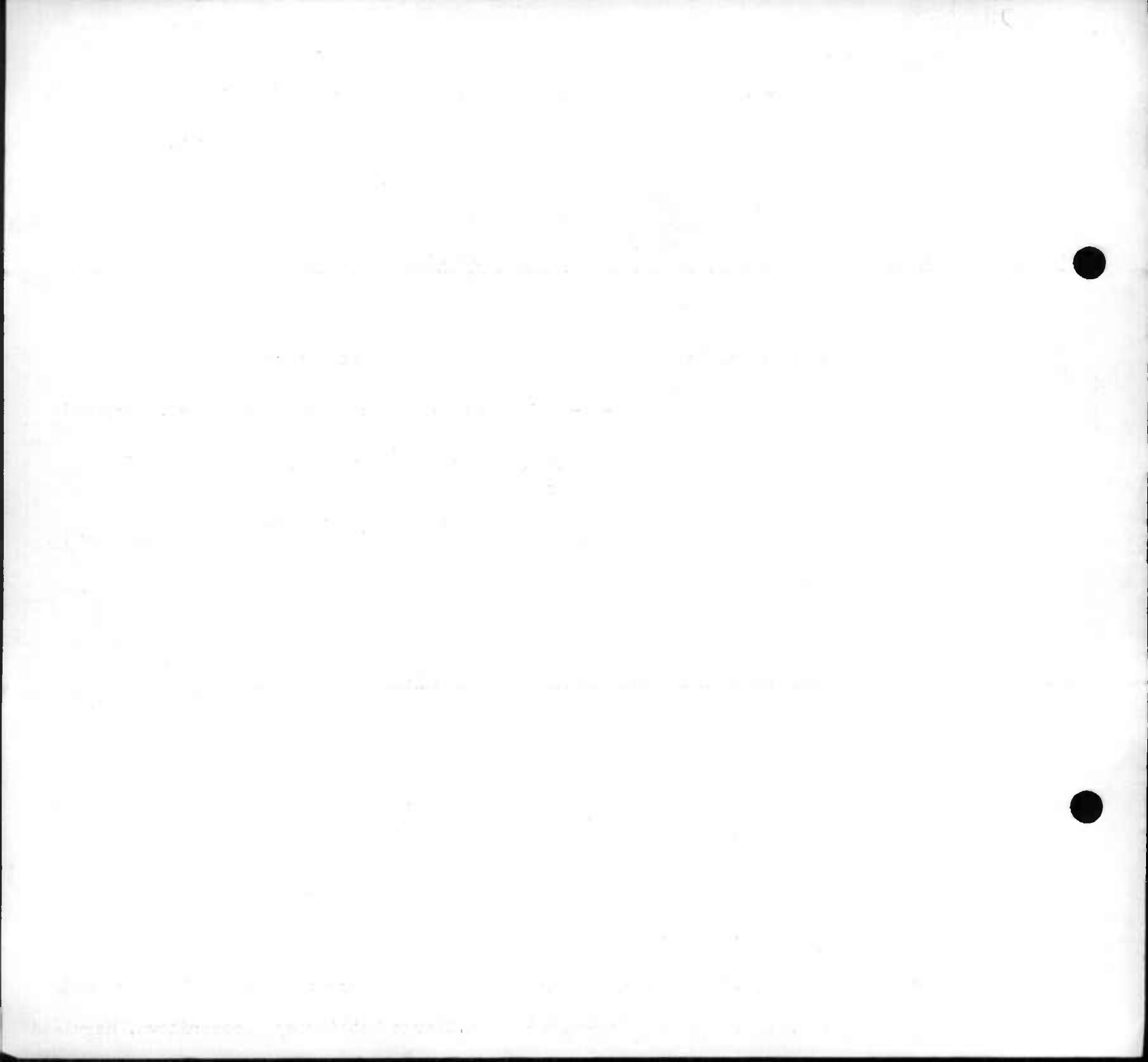
JUN 29 1972

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

W. Clarke Mattingley Leonardtown, Maryland



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

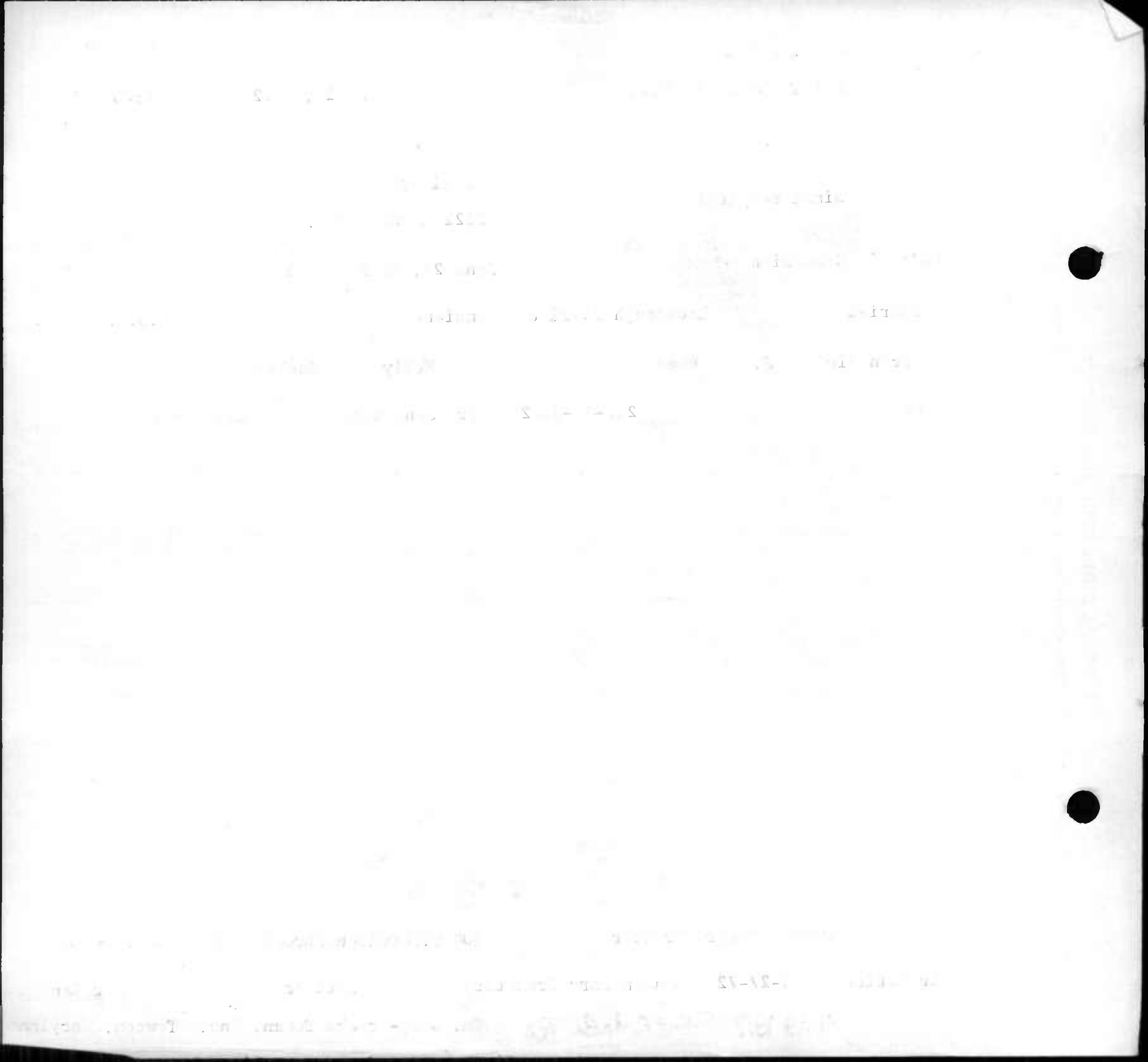
BIRTH NO. 72 06059		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X		REG. NO. 72 06059	
1. NAME OF DECEASED (Type or Print) BERNADINE SINGLETARY			2. DATE AND HOUR OF DEATH 6/22/72 10:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND 21205			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE DELAWARE B. COUNTY SUSSEX 107 C. CITY OR TOWN LINCOLN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER R.D. #1		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/52	9. AGE (In years last birthday) 18	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JESSE SINGLETARY			
14. MOTHER'S MAIDEN NAME ROSA MAE REDDICK		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 221 42 8456		17. INFORMANT Jesse Singletary Lincoln, Del.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ARD & long standing mitral disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary edema, low output (C) DUE TO, OR AS A CONSEQUENCE OF: Mitral valvular disease; Post op replacement			
19A. DATE OF OPERATION 6/21/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED M.D.		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/20 1972 to 6/22 1972 that (I) (we) last saw the deceased alive on 6/22/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Levi Watkins		23B. DATE SIGNED 6/29/72		23C. PHYSICIAN'S NAME (Type) LEVI WATKINS M.D.	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE June 27, 1972		24C. NAME OF CEMETERY OR CREMATORY Siloam		24D. LOCATION (City, town, or county) (State) Lincoln Delaware	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR P. E. E. Jones, Jr.		25C. FUNERAL DIRECTOR ADDRESS Clarence E. Young Milton, Del.	

3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

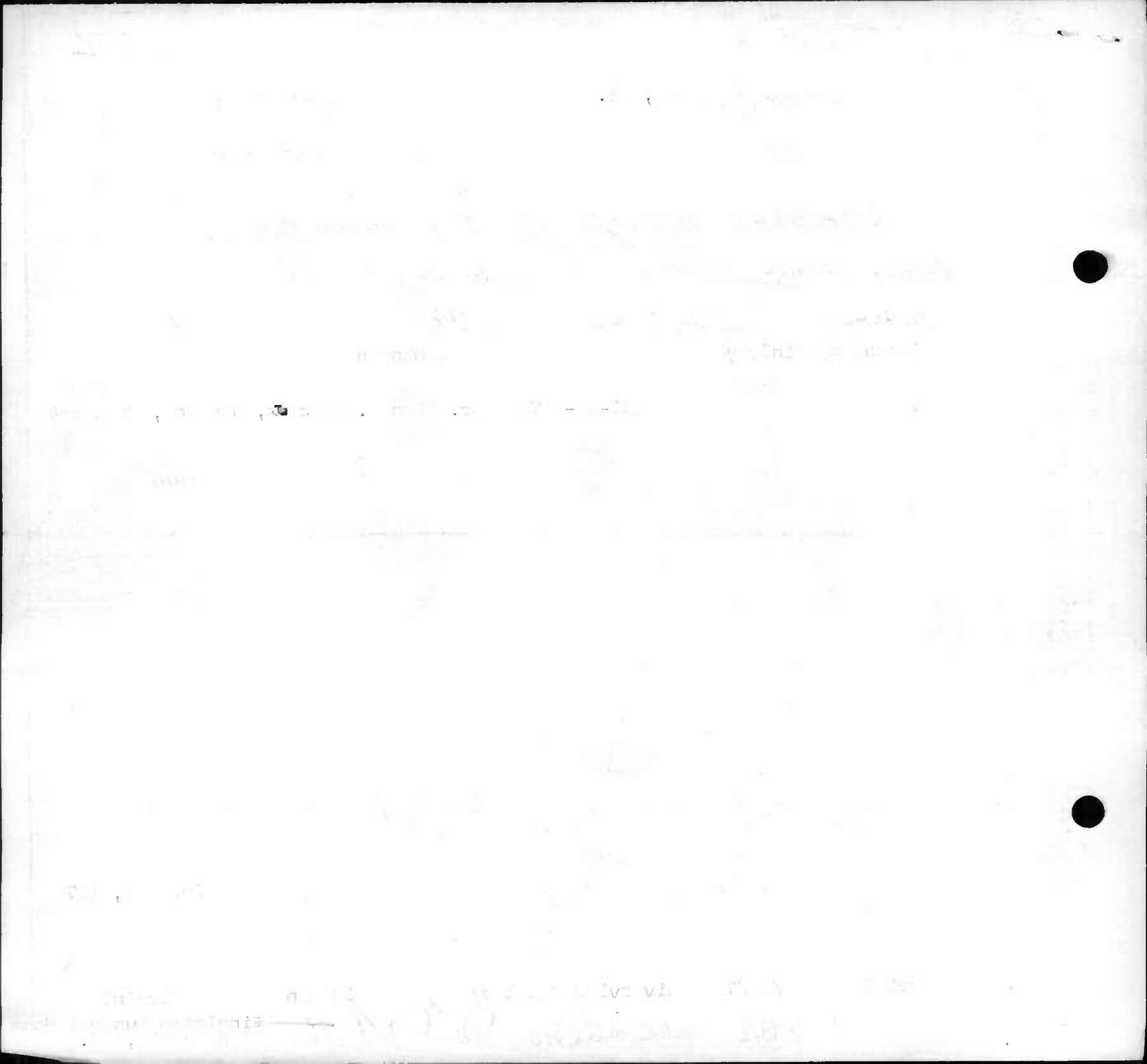
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06060	
BIRTH NO. 72 06060				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HUBERT CHARLES REED			2. DATE AND HOUR OF DEATH June 24, 1972 6:00 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2788 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3522 Hayward Ave.		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1889	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10B. KIND OF BUSINESS OR INDUSTRY Radebaugh Florist		11. BIRTHPLACE (State or foreign country) Indiana	
13. FATHER'S NAME Franklin J. Reed			14. MOTHER'S MAIDEN NAME Molly Beckel		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-5732		17. INFORMANT Mary Jane Reed ADDRESS Same as # 4E	
18. 4101 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6/25/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1969 to 1971 that (I) (we) last saw the deceased alive on July 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel Edward Proctor				23B. DATE SIGNED 6/25/72	
23C. PHYSICIAN'S NAME (Type) Samuel Edward Proctor				23D. ADDRESS 106 W. Madison Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6-27-72		24C. NAME OF CEMETERY or CREMATORY Loudon Park Crematory	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR P. R. E. Taylor, Jr.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Town, Inc.	
ADDRESS Towson, Maryland					



FUNERAL DIRECTOR: IMPORTANT

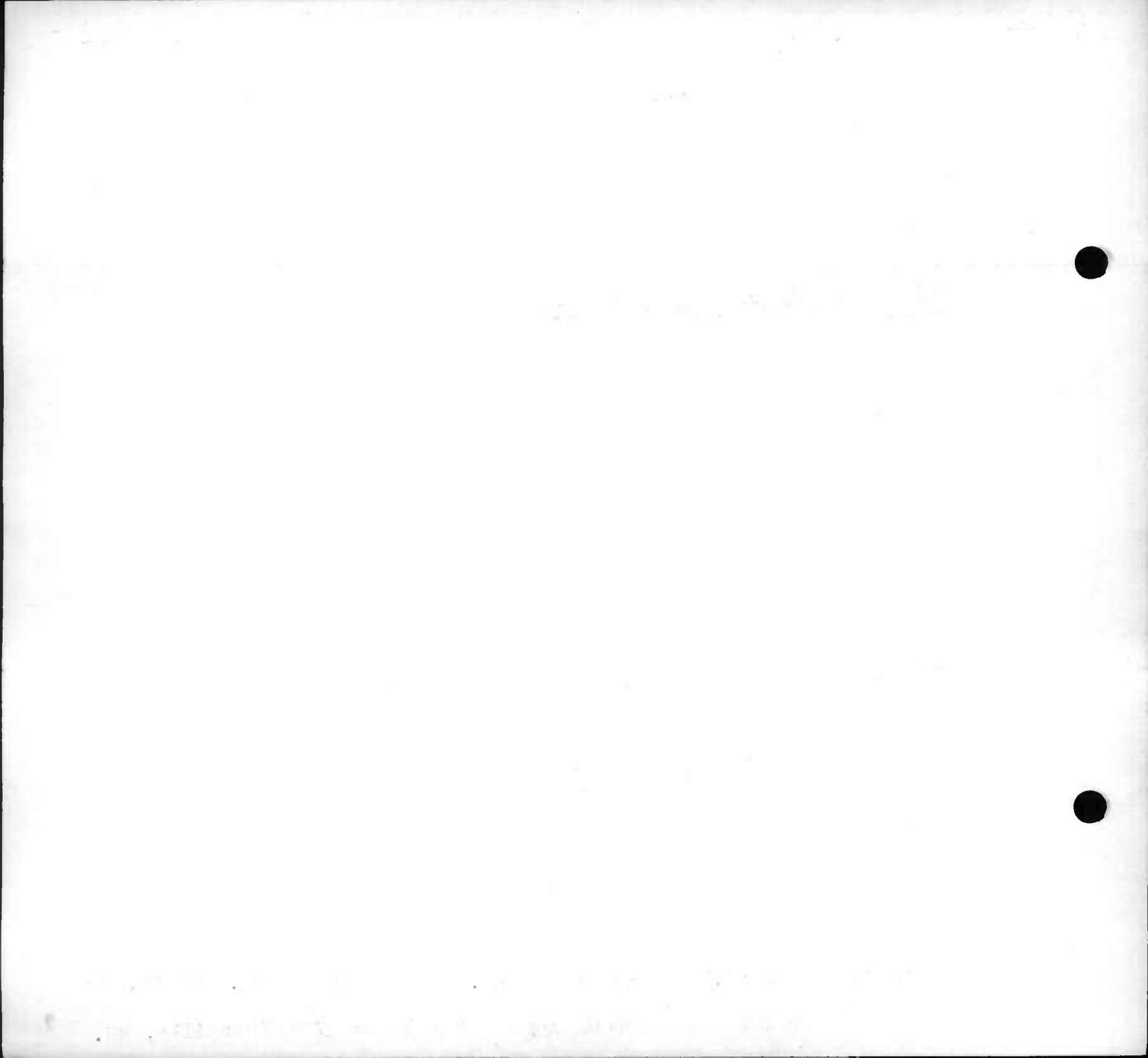
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06061		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06061
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>PEACOCK, PHOEBE E.</u>		2. DATE AND HOUR OF DEATH <u>6/26/72 at 8:30 P.M.</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>46 LUTHERAN HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Anne Arundel</u> C. CITY OR TOWN <u>LINTHICUM</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>304 CHURCH CIRCLE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-30-13</u>	9. AGE (In years last birthday) <u>58</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>DEPT. OF ED</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>
13. FATHER'S NAME (unknown) Winfrey		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>231-50-4374</u>		17. INFORMANT <u>Mr. Glen A. Peacock, husband, Same as 4E</u>
18. <u>182.7</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>METASTATIC CARCINOMA</u> <u>OF UTERUS.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>-</u> (C) <u>-</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>6/20/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>-</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>
22. I certify that (I) (this hospital) attended the deceased from <u>6/20/72</u> to <u>6/26/72</u> that (I) (we) last saw the deceased alive on <u>6/26/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>J. H. Sampat M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>June 26, 1972</u>
23C. PHYSICIAN'S NAME (Type) <u>J. H. SAMPAT M.D.</u>		23D. ADDRESS <u>LUTHERAN HOSP OF MARYLAND</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/30/72</u>	24C. NAME of CEMETERY or CREMATORY <u>Riverview Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Richmond Virginia</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>David J. Smith</u>
ADDRESS <u>Singleton Funeral Home Glen Burnie, Md.</u>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-143		72 06062		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 72 06062	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>IVAN Horace BAUBLITZ</u>			
2. DATE AND HOUR OF DEATH <u>6/23/72</u> <u>4.45 P</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS Hospital</u> <u>2525 Jk. FAYENS STREET</u> <u>BALTIMORE, Maryland 21223</u>				C. CITY OR TOWN <u>OWINGS MILLS</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <u>31 PLEASANTHILL Road</u>							
5. SEX <u>MALE</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>05-21-29</u>	9. AGE (In years last birthday) <u>43</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <u>Accountant</u> <u>Unemployed Disabled</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Auto Dealer</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>							
13. FATHER'S NAME <u>CLARENCE BAUBLITZ</u>				14. MOTHER'S MAIDEN NAME <u>MYRTLE KELLY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>213-28-8759</u>		17. INFORMANT <u>PT'S CHART</u> <u>BON SECOURS Hospital</u>	
18. <u>19901</u> CAUSE OF DEATH				ADDRESS <u>2525 FAYENS STREET, 21223</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____ DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>6/22</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Thyroidectomy closed</u> <u>Thyroidectomy done due to hyperplasia</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <u>6/20</u> 19 <u>72</u> to <u>6/22</u> 19 <u>72</u> that (H) (we) last saw the deceased alive on <u>6/23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Arvo Rance</u> M.D. DEGREE				23B. DATE SIGNED <u>6/23/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>ARVO RANCE</u> M.D. DEGREE				23D. ADDRESS <u>Bon Secours Hosp. Balto. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>June 26, 1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Evergreen Mem. Gardens Finksburg, Carroll, Md</u>		24D. LOCATION (City, town, or county) (State) <u>Carroll, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>6/29 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>H. E. Schardt</u>		ADDRESS <u>Owings Mills, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06063		BALTIMORE CITY HEALTH DEPARTMENT		72 06063	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. HELEN LOUISE THOMAS					
1. NAME OF DECEASED (Type or Print) THOMAS, HELEN L.		2. DATE AND HOUR OF DEATH 6/25/72 11:40 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSP. 3001, SOUTH HANOVER ST. BALTIMORE 21230.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2814 Vermont Ave.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-96	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PA	
13. FATHER'S NAME GRIER XXXXXXXX Townsley		14. MOTHER'S MAIDEN NAME IMOGENE DIVERSY.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 171-03-7161A		17. INFORMANT Jean Kosar, 2814 Vermont Ave., Baltimore	
18. 209X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) from positive Pulmonary Septicemia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: with Myelofibrosis. (B) DUE TO, OR AS A CONSEQUENCE OF: Myelofibrosis on treatment. (C) _____			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Myelofibrosis on treatment.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 6-24-72 1972 to 6-25-1972 1972, that (H) (we) last saw the deceased alive on 6-25-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R.B. Patel				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) R.B. Patel		23D. ADDRESS c/o S.B.C.H. 3001, S. Hanover STREET, BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/72		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) Glen Burnie, A.A.Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972			
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce, 4001 Ritchie Hgwy., Baltimore, Md.			

[The page contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs and possibly a list or table structure, but the characters are too light to transcribe accurately.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06064	
BIRTH NO. 72 06064				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BOSTON, JOHN HENRY			2. DATE AND HOUR OF DEATH June 25, 1972 6:20 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1606		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore e, Maryland 21218			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2925 W. Mosher Street					
5. SEX MALE	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/09	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY DEPT OF MTR VEH.	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN H. BOSTON			14. MOTHER'S MAIDEN NAME ELIZABETH FREEMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 219-05-5623	17. INFORMANT ADDRESS CLIN RCDS, VAHOSP, BALTIMORE, MARYLAND 21218		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION NONE 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: 5 min (B) DEHYDRATION AND PROBABLE PULMONARY EMBOLUS DUE TO, OR AS A CONSEQUENCE OF: 4 days (C) UNRESECTABLE CARCINOMA OF LARYNX years		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (X) (this hospital) attended the deceased from June 13, 19 72 to June 25, 19 72, that (X) (we) lost saw the deceased alive on June 25, 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] 23C. PHYSICIAN'S NAME (Type) ROY A. MEALS, M.D.			23B. DATE SIGNED [Signature] 23D. ADDRESS VAH, BALTIMORE, MARYLAND 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-29-72	24C. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS Morton Dyett Funeral Home 1701 LAURENS ST. Baltimore, Md.	

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• *Chrysomelids*

2

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25-23-2 11/1/84

[illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SYLVESTER JOHNSON		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour	M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour	M.
				6	25	1972	12:05p	
6. SEX male		7. RACE negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1403		
9. DATE OF BIRTH 3-12-04		10. AGE (In years last birthday) 68		11. BIRTHPLACE (State or foreign country) Reedsville, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		
17. SOCIAL SECURITY NO. 239-18-7104		18. INFORMANT Mrs. Mary Johnson		ADDRESS 2101 Druid Hill Avenue		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.4 I		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:						
(C) DUE TO, OR AS A CONSEQUENCE OF:								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?				
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. 6-29-72		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett Funeral Home		ADDRESS 1701 Laurens St.		

Walter V. Walker, Raleigh, N.C.

WALTER V. WALKER
Raleigh, N.C.

Post Office Box 17, Raleigh, N.C.

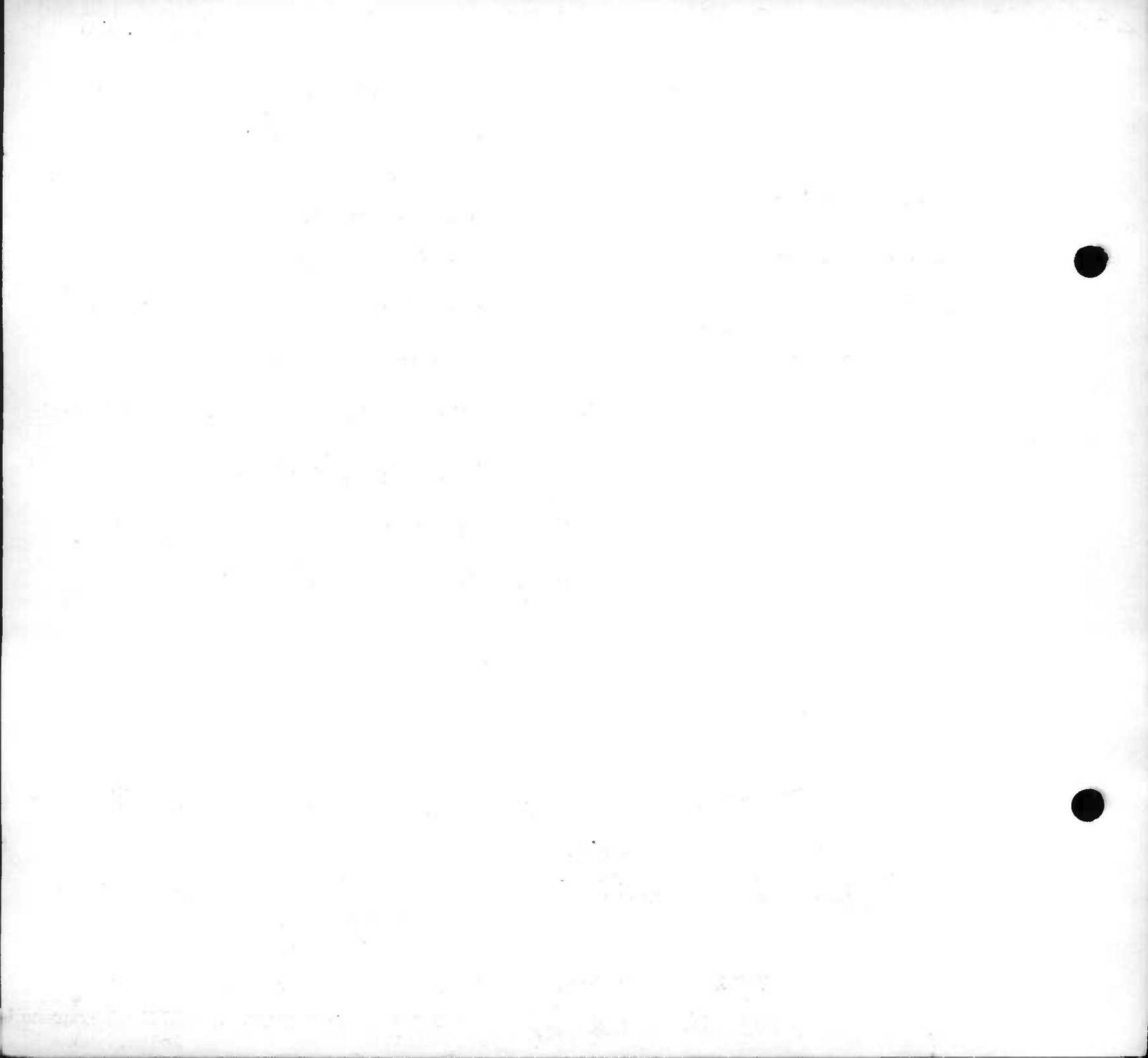
Walter V. Walker, Raleigh, N.C.

Post Office Box 17, Raleigh, N.C.

Walter V. Walker, Raleigh, N.C.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 Q6066	
BIRTH NO. 72 Q6066		2. DATE AND HOUR OF DEATH 6/28/72	
1. NAME OF DECEASED (Type or Print) LEE, Rebecca		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1607	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1411 Bloomingdale Rd.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negroid	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/19/04	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		11. BIRTHPLACE (State or foreign country) Friendship, Md.	
13. FATHER'S NAME MacMillian Carter		14. MOTHER'S MAIDEN NAME Harriett Ann Turner	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-16-7050A	
17. INFORMANT Irene Vandervall		ADDRESS 1411 Bloomingdale	
18. 423 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Chronic CHF Myocardiohypertrophy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate? years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/1 19 72 to 6/27 19 72 that (I) (we) last saw the deceased alive on 6/22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Daniel V. Lindenstruth		23B. DATE SIGNED 6/28/72	
23C. PHYSICIAN'S NAME (Type) Daniel V. Lindenstruth, M.D.		23D. ADDRESS 827 Linden Avenue Marland General Hospital, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Wesport, Md. 21225	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOME		ADDRESS 1701-31 Laurens Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-531

72 06067

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 06067

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Otha Mayor Montague

2. DATE AND HOUR OF DEATH

6-27-72

2:50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39

Provident Hospital

2600 Liberty Height Ave.
Baltimore, Md. 21215

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1608 Druid Hill Avenue

5. SEX

Male

6. RACE

Black

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

08-17-30

9. AGE (In years last birthday)

41

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Otha Montague, Sr.

14. MOTHER'S MAIDEN NAME

Lena Noah

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

213-36-0245

17. INFORMANT

Mr. George Montague (Brother)

ADDRESS

same

18.

152,01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

RLL Pneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 months

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Cx of Cardiovascular

4 yrs

(C)

with splenic metastasis

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 04-13 19 72 to 06-27 19 72 that (I) (we) last saw the deceased alive on 06-27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. A. MALABRIGO, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

June 27, 1972

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

Provident Hospital 2600 Liberty Height Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-1-72

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 29 1972

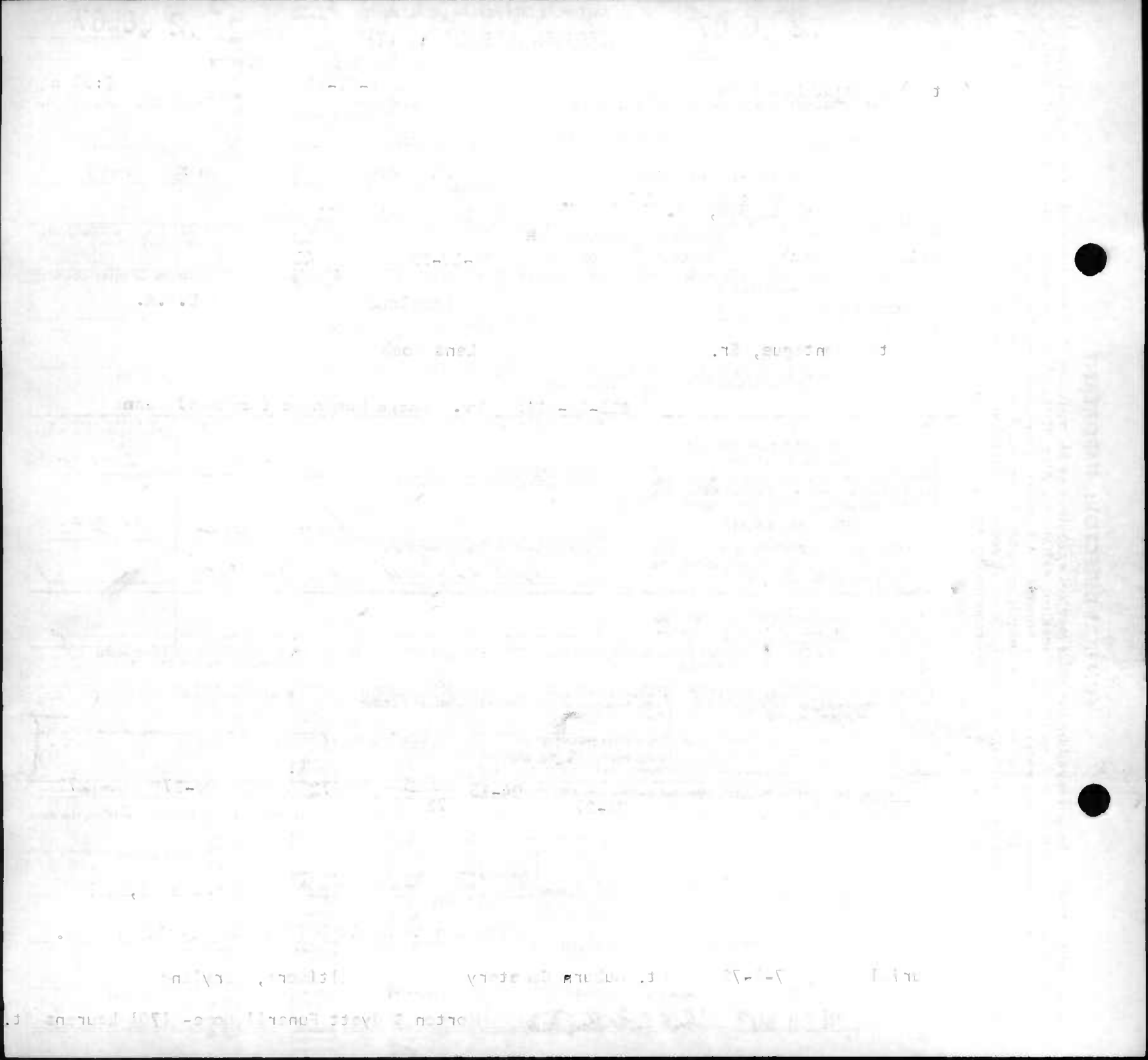
25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

Morton & Dyett Funeral Home- 1701 Laurens St.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400 1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 06068

BIRTH NO.

72 06068

1. NAME OF DECEASED
(Type or Print)

HILL, HATTIE

2. DATE AND HOUR OF DEATH

6/27/72

6:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 LUTHERAN Hospital
Baltimore, Md. 21216

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1670 Mountmor Court

5. SEX

F

6. RACE

B

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

12-26-00

9. AGE (in years last birthday)

71

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215120350A

17. INFORMANT

UREATHER, Diggs (daughter) 2006 E. Boston St.

ADDRESS

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Haemorrhage

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Bilateral C. V. A.

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/25/1972 to 6/27/1972 that (I) (we) last saw the deceased alive on 6/27/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

D. S. KARBHARI

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/27/72

23C. PHYSICIAN'S NAME (Type)

D. S. KARBHARI

23D. ADDRESS

Lutheran Hospital.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-30-72

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Pk.

24D. LOCATION

(City, town, or county)

Balto., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 29 1972

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

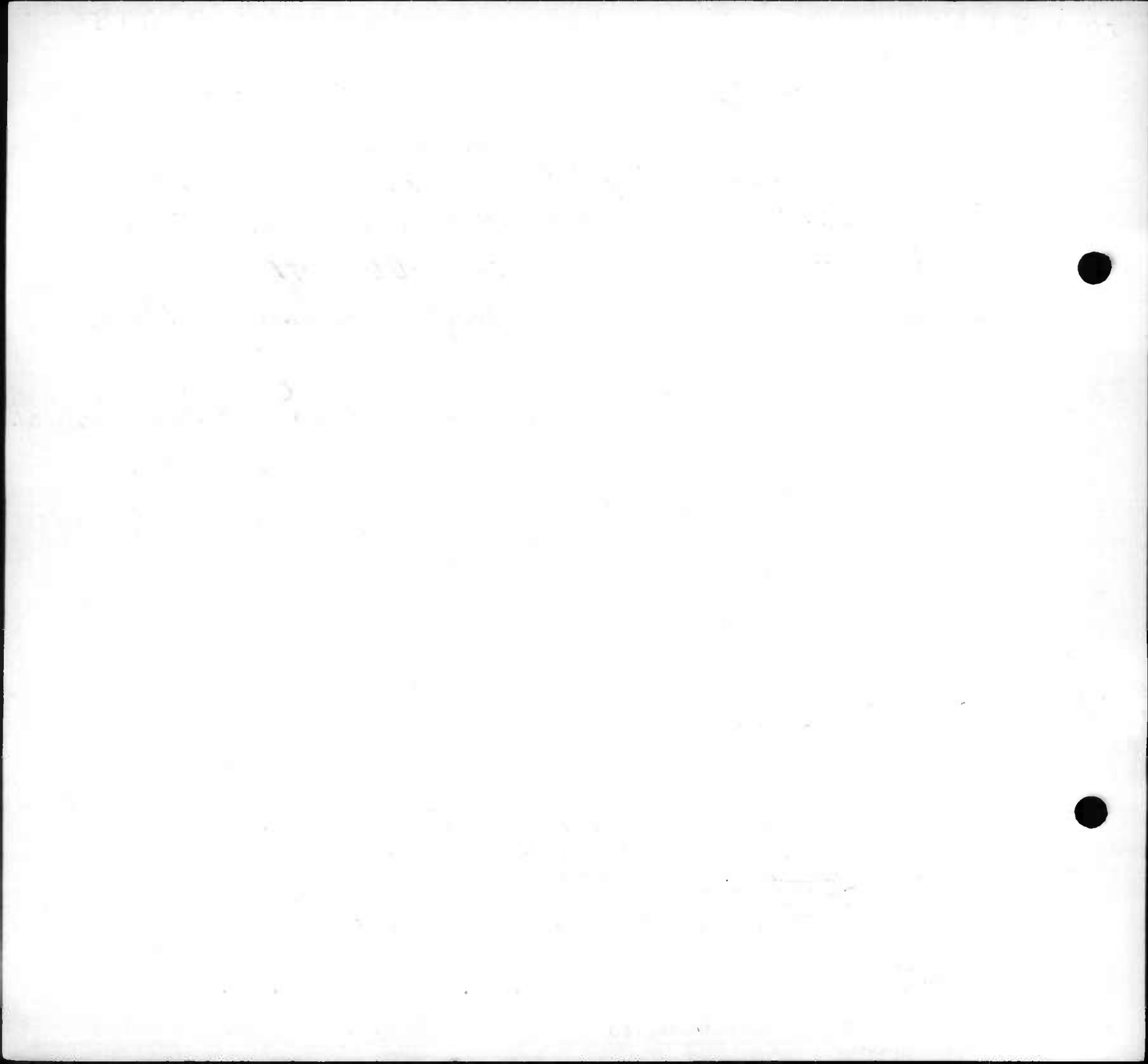
25C. FUNERAL DIRECTOR

Kelson F.H.

V. Bailey

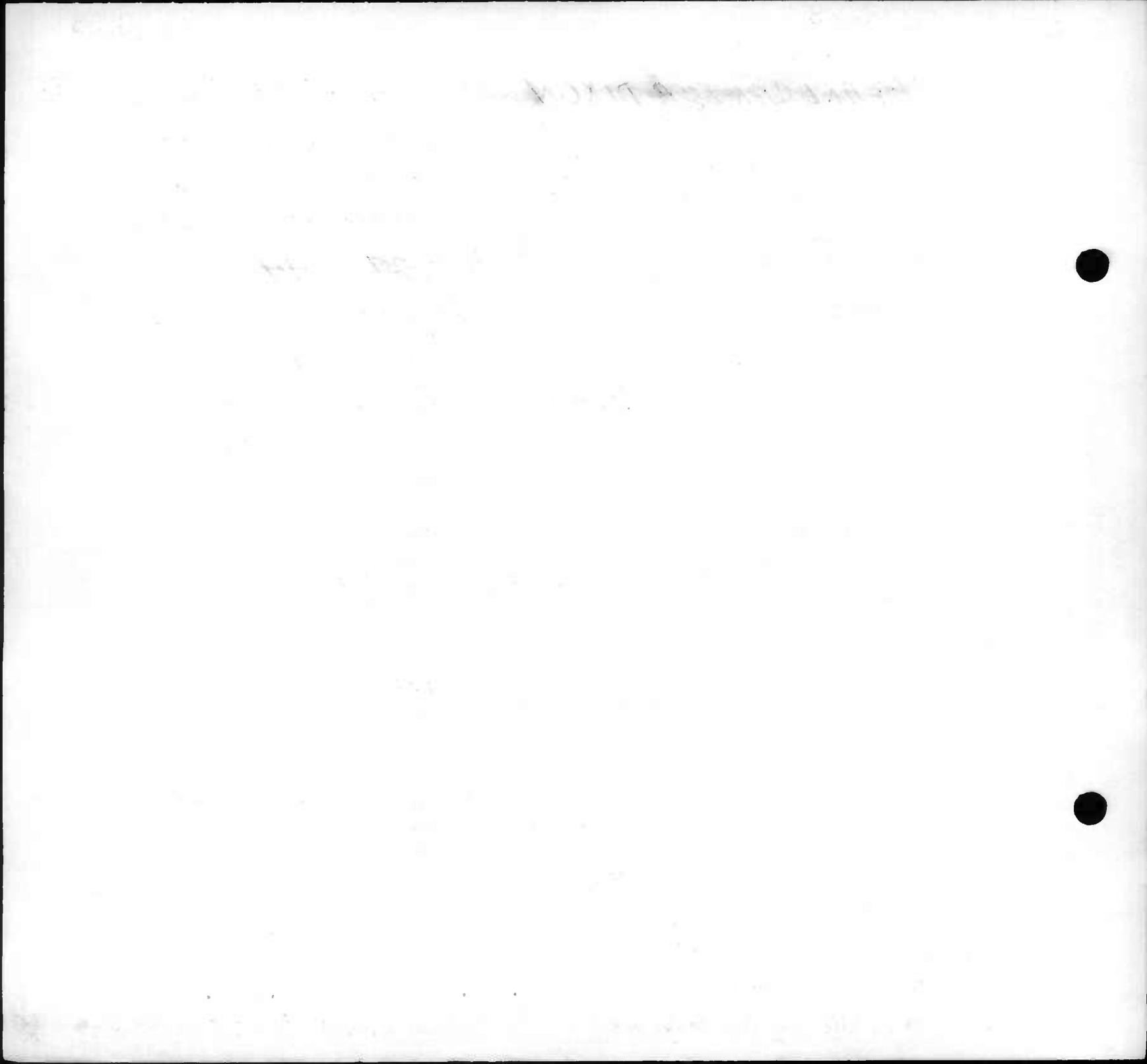
ADDRESS

1348 Calhoun Street



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

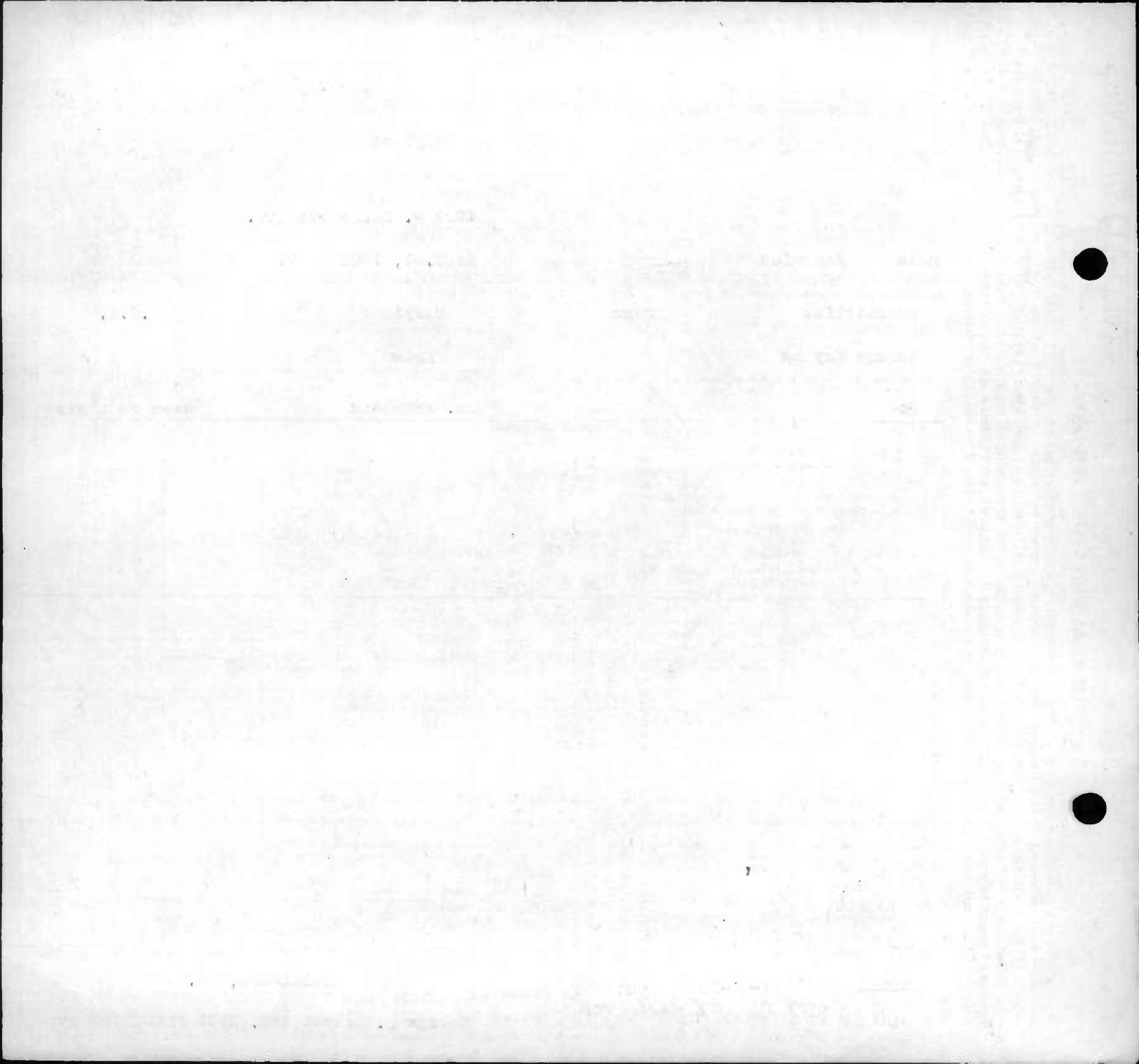
D-2501		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06069
BIRTH NO. 72 06069		1. NAME OF DECEASED (Type name) PEARL CARTER DIXON		
2. DATE AND HOUR OF DEATH 12:15 AM June 28, 1972		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 406 Edgewood Street B. COUNTY 2037		C. CITY OR TOWN Baltimore		
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER Maryland 21229		
5. SEX Female	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-27	9. AGE (In years last birthday) 44
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Levi Carter		
14. MOTHER'S MAIDEN NAME Pearl Carter		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 220209170		17. INFORMANT Mother Pearl Carter		
ADDRESS 406 Edgewood St.		18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE cardio-pulm. Failure DUE TO, OR AS A CONSEQUENCE OF: (B) GI bleed DUE TO, OR AS A CONSEQUENCE OF: (C) SBE, renal Failure		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4-16 19 72 to 6-28 19 72 that (I) (we) last saw the deceased alive on 6-27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE John Hughes MD		23B. DATE SIGNED 6-28-72		23C. PHYSICIAN'S NAME (Type) John Hughes MD
23D. ADDRESS Univ. of Maryland Hosp., Balto., Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7-1-72		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Balto., Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR V. Bailey
ADDRESS Kelson P.H. 1348 Calhoun Street				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

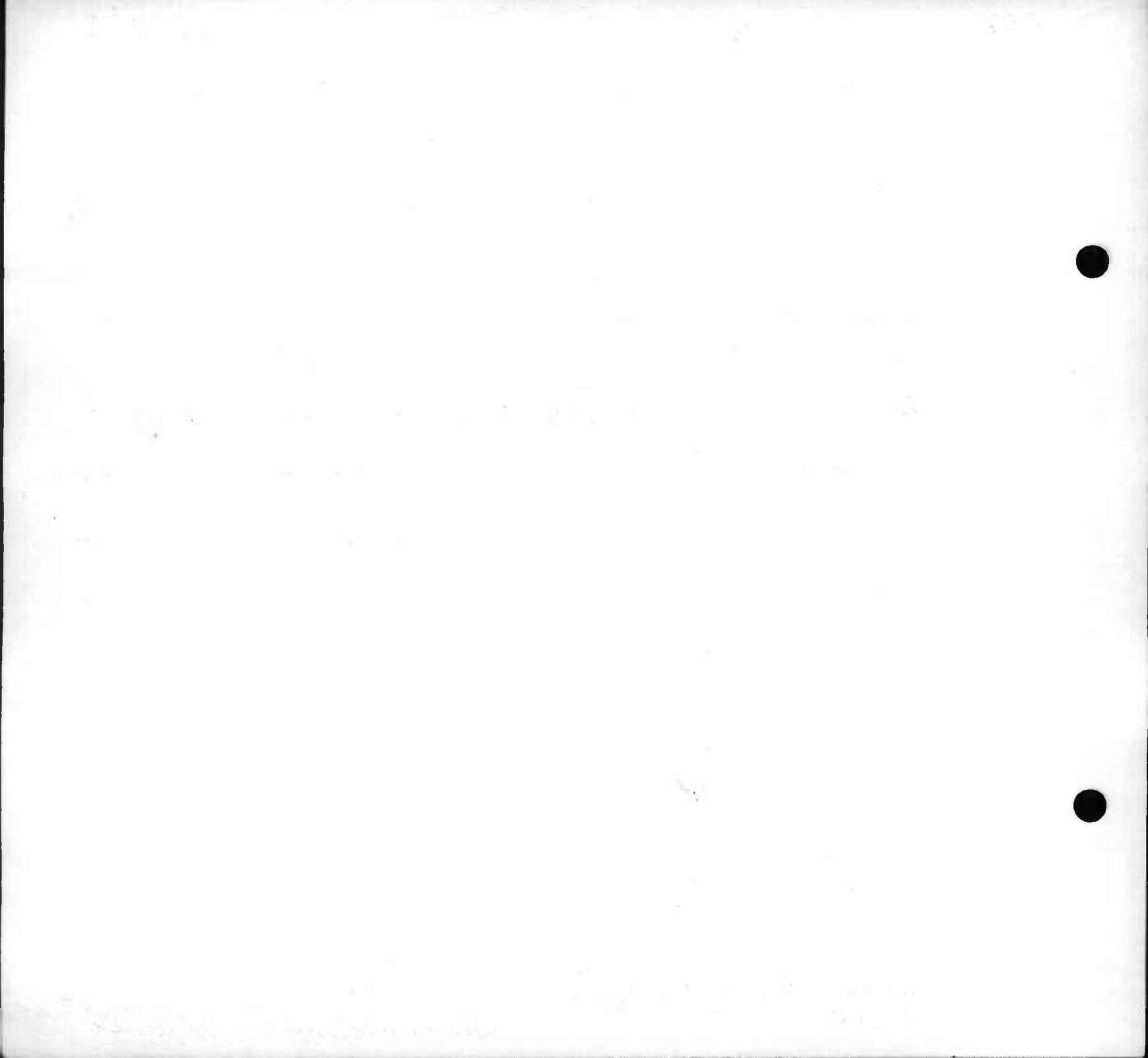
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 06070</u>
BIRTH NO. <u>72 06070</u>		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>ALBERT G KAYLUS</u>		2. DATE AND HOUR OF DEATH <u>6-27-72</u> <u>11</u> <u>A</u> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> <u>1922 W FAIRMOUNT AVE</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2001</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1922 W. Fairmount Ave.</u>
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Drugs</u>
13. FATHER'S NAME <u>George Kaylus</u>		14. MOTHER'S MAIDEN NAME <u>Kate</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.
17. INFORMANT <u>Mrs. McKeldin</u>		ADDRESS <u>same as above</u>
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Cerebro-vascular accident</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized Arteriosclerosis</u> <u>(C) (D) hemiplegia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>(D) hemiplegia</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1971</u> to <u>June 27 1972</u> , that (I) (we) last saw the deceased alive on <u>June 2 1972</u> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Benigno R. LAZARO</u>		23B. DATE SIGNED <u>6-27-72</u>
23C. PHYSICIAN'S NAME (Type) <u>Benigno R. LAZARO</u>		23D. ADDRESS <u>59 Dundalk or Balto. Adv 222</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-28-72</u>
24C. NAME OF CEMETERY or CREMATORY <u>Most Holy Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.B.</u>
25C. FUNERAL DIRECTOR <u>George L. Schwab INC.</u>		ADDRESS <u>2101 FREDERICK AVE</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 06071		REG. NO. 72 06071	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SAMUEL G SICKEL		2. DATE AND HOUR OF DEATH 6-28-72 9:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 2003			
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1925 CHRISTIAN ST			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/95	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glassworker		10B. KIND OF BUSINESS OR INDUSTRY Glass		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME SAMUEL SICKEL		14. MOTHER'S MAIDEN NAME MARY PARR	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-76944		17. INFORMANT ADDRESS Mr. Cavey - 1925 Christian St.	
18. 492X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS	
		(B) Diffuse emphysema of lungs DUE TO, OR AS A CONSEQUENCE OF:		YEARS	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2/1/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from 6-28 1972 to 6-28 1972 that (I) (we) lost saw the deceased alive on 6-28 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vilavivan Thitivarana		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-28-72	
23C. PHYSICIAN'S NAME (Type) VILAVIVAN THITIVARANA, M.D.		23D. ADDRESS B.S.H.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/72		24C. NAME OF CEMETERY OR CREMATORY Crest Lawn Cem.	
24D. LOCATION Howard Co. Md.		(City, town, or county)		(State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR James E. Hester		25C. FUNERAL DIRECTOR 210 S. Frederick Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06072	
BIRTH NO. 72 06072				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Starling, Alice JOYCE</u>		2. DATE AND HOUR OF DEATH <u>6/28/72</u> <u>12:30 pm</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>202</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1748 E. Lombard Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/11</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>DETROIT MICH</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George McKay</u>			
14. MOTHER'S MAIDEN NAME <u>Carrie Grover</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIAM O STARLING 1748 E LOMBARD ST</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hepatic Comp, Pneumonia</u> <u>Metastatic Carcinoma of Colon</u>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/28</u> 19 <u>72</u> to <u>6/28</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6/28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Barry Cooper MD</u>		23B. DATE SIGNED <u>6/28/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Barry Cooper, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>JULY 11 1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt CARMEL CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>ODONNELL ST BALTO, MD</u>		25A. DATE RECEIVED BY HEALTH DEPT. & 25B. NAME OF REGISTRAR <u>JUN 29 1972</u>			
25C. FUNERAL DIRECTOR ADDRESS <u>DIPPEC BROS INC 1800 E LOMBARD ST</u>					

A20

2002-2003

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
72 Q6073						72 06073	
1. NAME OF DECEASED (Type or Print Name) CELIA CEALY J. ZILTKOW				2. DATE AND HOUR OF DEATH JUNE 28, 1972 5 ³⁰ A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Friedler's Guest House				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY 3710 Liberty Heights Ave BALTO C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/88	9. AGE (in years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PACKER		10B. KIND OF BUSINESS OR INDUSTRY LORD MOTTS CO		11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME VINCENT JAGODZIENSKI				14. MOTHER'S MAIDEN NAME CATHERINE ROSSLE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-03-48		17. INFORMANT CATHERINE RATAJCZAK 404 S STREEPER 21234 ST		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				CAUSE OF DEATH Broncho-pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (C) Chronic Blain Syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 weeks 3 years 2 years	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 11 1972 to June 28 1972 that (I) (we) last saw the deceased alive on June 28 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Manuel Levin M.D.				23B. DATE SIGNED 6/28/72		23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 29-72		24C. NAME OF CEMETERY or CREMATORY HOLY CROSS CEMETERY		24D. LOCATION (City, town, or county) (State) GERMAN HILL RD BALTO, MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR DIPPEL BROS INC		ADDRESS 1800 E LOMBARD ST	

RETIRED PAPER WORK MORTAL BATHING ROOM
VINCENT JACOBOWSKI CATHERINE ROSS

CATHERINE PATRICKSON

10-10-10 10-10-10 10-10-10 10-10-10 10-10-10
10-10-10 10-10-10 10-10-10 10-10-10 10-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 06074
CERTIFICATE OF DEATH				REG. NO. 72 06074
BIRTH NO. 72 06074		2. DATE AND HOUR OF DEATH 6/25/72 6:15 AM		
1. NAME OF DECEASED (Type or Print) Wilson, Floyd		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 1504 N. Eden St. Balto. 13. Maryland		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 44		C. CITY OR TOWN City Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M		6. RACE B		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-12-82		9. AGE (in years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Charles Wilson		14. MOTHER'S MAIDEN NAME UNKNOWN
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 717-10-2017		17. INFORMANT MART M. WILSON
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DUNG atelectasis - subtotal Colo. 10 days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: p.p. MI.		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Biventricular				
19A. DATE OF OPERATION 6/15/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED R. Bleeding		20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6/15/1972 to 6/25/1972 that (I) (we) lost saw the deceased alive on 6/25 19/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ghassan Khani		23B. DATE SIGNED 6/25/72		23C. PHYSICIAN'S NAME (Type) R. Doyle
23D. ADDRESS U.M.H.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-72		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery
24D. LOCATION (City, town, or county) (State) Balto Md.				
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR W.M.C. MARCH 928 E NORTH AVE

9/20/72 - Rectal Bleeding caused
by Diverticulosis of
entire colon

Letter from Union Memorial Hosp.
filed in Ser. of Bristol - American
Bldg

8 Dec 16
James M. M.

6/12

15/12/12

11/2/72

NO

2/11/12/12

1/11/12/12

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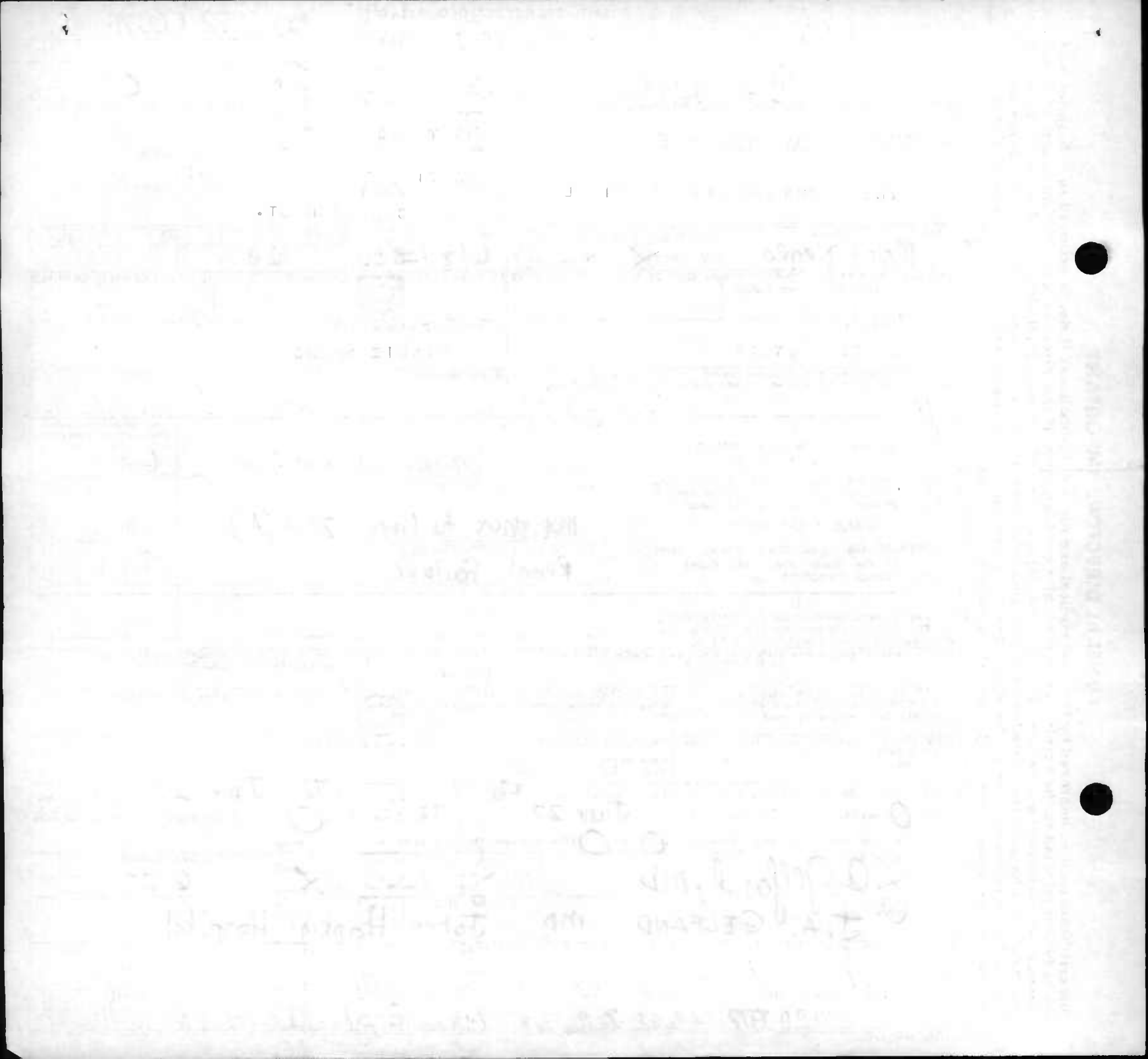
James M. M.

James M. M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06075	
BIRTH NO. 72 06075					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
TAYLOR, ROBERT JAMES			6/27/72 6:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL			MARYLAND		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 1008 Mc DONOUGH ST.		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/8/06	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES TAYLOR			14. MOTHER'S MAIDEN NAME MOLLIE SPENCER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-01-5170		17. INFORMANT Dorothy Rice-4407 Springdale Ave
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Squamous Carcinoma of Lung			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Metastases to Liver 20 to (A) 6 mos		
			(C) Renal failure ? time		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 9 19 72 to June 27 19 72 that (I) (we) lost saw the deceased alive on June 27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. A. Gelfand, MD				23B. DATE SIGNED 6-27-72	
23C. PHYSICIAN'S NAME (Type) J. A. GELFAND MD				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-72		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	
24D. LOCATION Arbutus, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972			
25B. NAME OF REGISTRAR P. R. E. Johnson		25C. FUNERAL DIRECTOR Milton E. Erickson-1129 N. Caroline St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 Q6076	
72 Q6076				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CATHERINE YEAGER		June 26, 1972 5:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 3728 Eastern Ave. Balto., 21224, Md.			Md. 2609		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3728 Eastern Ave. # 21224.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8-14-78.	93	Retired
			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Baltimore, Md.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George Metzger			Anna Schader R		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No -----		219-01-6139		D Fredericka Metzger Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Dementia		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Arteriosclerotic Cardio Vascular		
			Hypertension		
			(C) -----		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/1/72 to 5/1/72, that (I) (we) last saw the deceased alive on 5/1/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ariemio Arciaga, Jr.				6/27/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ARIEMIO ARCIAGA, JR.				3501 Fait Ave., Balto., 21224, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-29-72		Trinity Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 28 1972		Robert E. Fisher, M.D.		Charles S. Giller 901 S. Conkling St. Balto., 21224, Md.	

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 06077

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLENE KENNELLY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 24, 1972 Hour 10:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 24, 1972 10:30 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Prince Georges	
9. DATE OF BIRTH 18 Nov 1941		10. AGE (In years lost birthday) 30	
11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? US America	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Homemaking	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 356-34-5726	
15. FATHER'S NAME William Mueller		15. MOTHER'S MAIDEN NAME Audrey Innis	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 356-34-5726	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E8/511 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		18. INFORMANT Robert W. Kennelly ADDRESS same as #5e	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 6-24-72 8:05 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? US 301, N. of Cedar Road, Cedar, Md.		22F. HOW DID INJURY OCCUR? Passenger in auto - thrown out of auto after fixed object collisions	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1972	
24C. NAME OF CEMETERY or CREMATORY Arlington National Cem.		24D. LOCATION (City, town, or county) (State) ARLINGTON COUNTY, VIRGINIA	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR P. E. Faber, M.D.	
25C. FUNERAL DIRECTOR W.W. Chambers Co.		ADDRESS Riverdale, Md. 20840	

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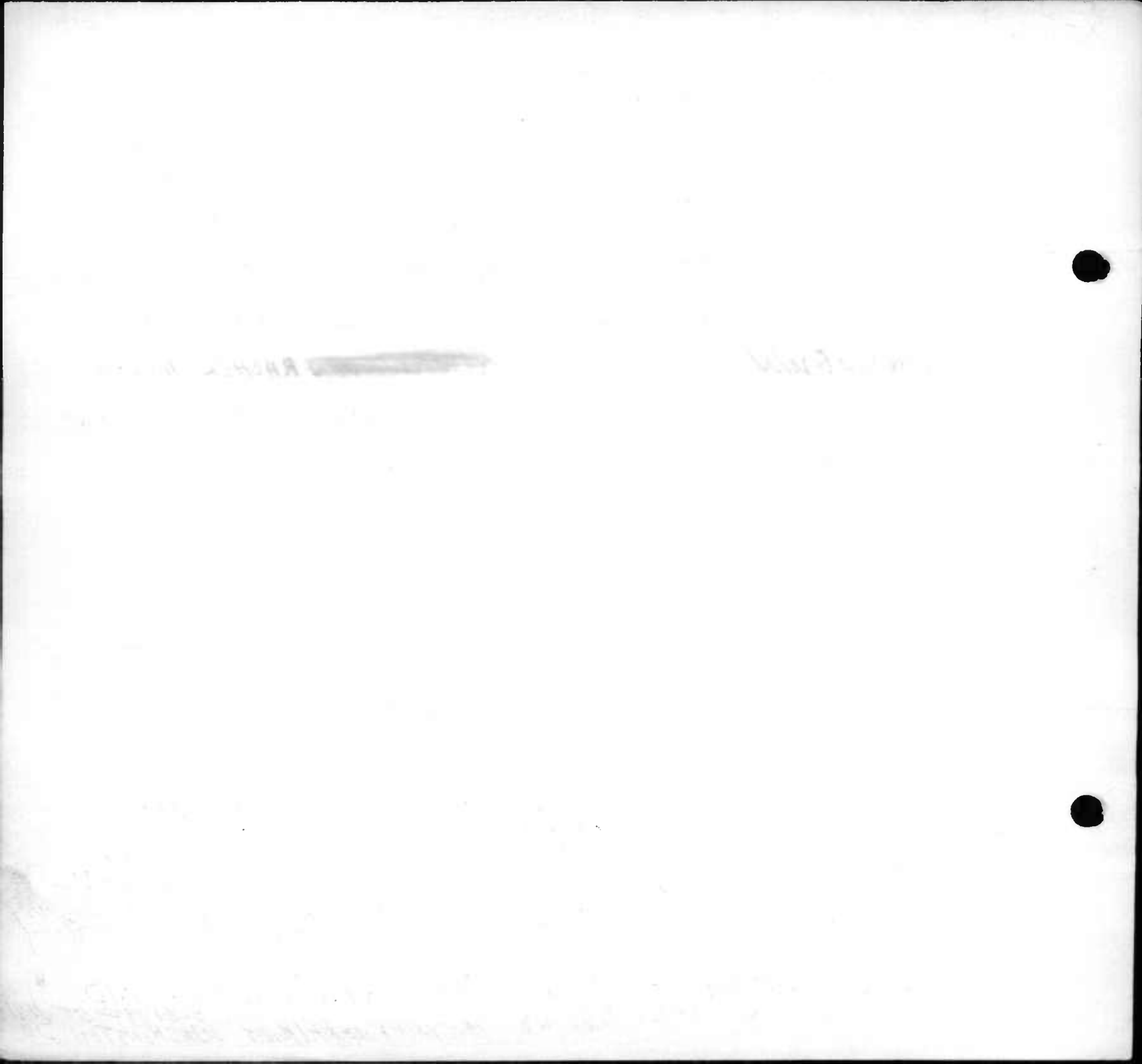
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06078	
BIRTH NO. 72 06078		1. NAME OF DECEASED (Type or Print) Octavia L. Trent		2. DATE AND HOUR OF DEATH 6-25-72 8 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE md		B. COUNTY 1001	
Granada Nursing Home 9017 Liberty Heights Ave Baltimore, md		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 113 E. Preston St		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/2/90	
9. SEX Female		10. RACE Black		9. AGE (In years last birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRY WORKER		10B. KIND OF BUSINESS OR INDUSTRY LAUNDRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME RACHEL MOORE		12. CITIZEN OF WHAT COUNTRY USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO NO		16. SOCIAL SECURITY NO. 578-05-3510		17. INFORMANT PEARL HAWKINS 1314 24TH ST NE WASH DC	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ARTEROSCLEROTIC HEART DISEASE		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/10/70 19 to 6/25/72 19 that (I) (we) last saw the deceased alive on 6/25/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) HOLLIS DEUNAKINE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-30-72		24C. NAME OF CEMETERY or CREMATORY HARMONY CEMETERY	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR MODERN FUNERAL HOME WASHINGTON, DC	
24D. LOCATION (City, town, or county) LANDOVER, PGC MD		24E. ADDRESS 3881 4th ST NW		24F. PHONE NO. 3881 4th ST NW	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06079	
BIRTH NO. 72 06079				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Chester Douglas DOUGLAS CHESTER HOLE			2. DATE AND HOUR OF DEATH June 25, 1972 2: 25PM x		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY PG 6600 C. CITY OR TOWN Upper Marlboro D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 11107 Woodlawn Blvd.		
5. SEX M	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/10	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soil Conservationist			11. BIRTHPLACE (State or foreign country) Oregon		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Carl C. Hole			14. MOTHER'S MAIDEN NAME Eva L. Fox		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USAF		16. SOCIAL SECURITY NO. ?	17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. 191X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Left frontoparietal DUE TO, OR AS A CONSEQUENCE OF: glioblastoma, multiforme ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Right pulmonary embolus			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yrs. Days		
19A. DATE OF OPERATION 22		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> Work At Work	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from May 31 19 72 to June 25 19 72 , that (I) (we) last saw the deceased alive on June 25 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vijal L. Bauer, R.D.				23B. DATE SIGNED 6/26/72	
23C. PHYSICIAN'S NAME (Type) Vijal L. Bauer, Sr. Surg (R)			23D. ADDRESS US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 6-29-72	24C. NAME OF CEMETERY or CREMATORY Gettysburg Natl. Cem.	24D. LOCATION (City, town, or county) (State) Gettysburg, Pennsylvania		
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Feltz, R.D.	25C. FUNERAL DIRECTOR Robt E Wilhelm		
Funeral Home Suitland, Rd., Suitland, Md.					

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72 06080

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06080

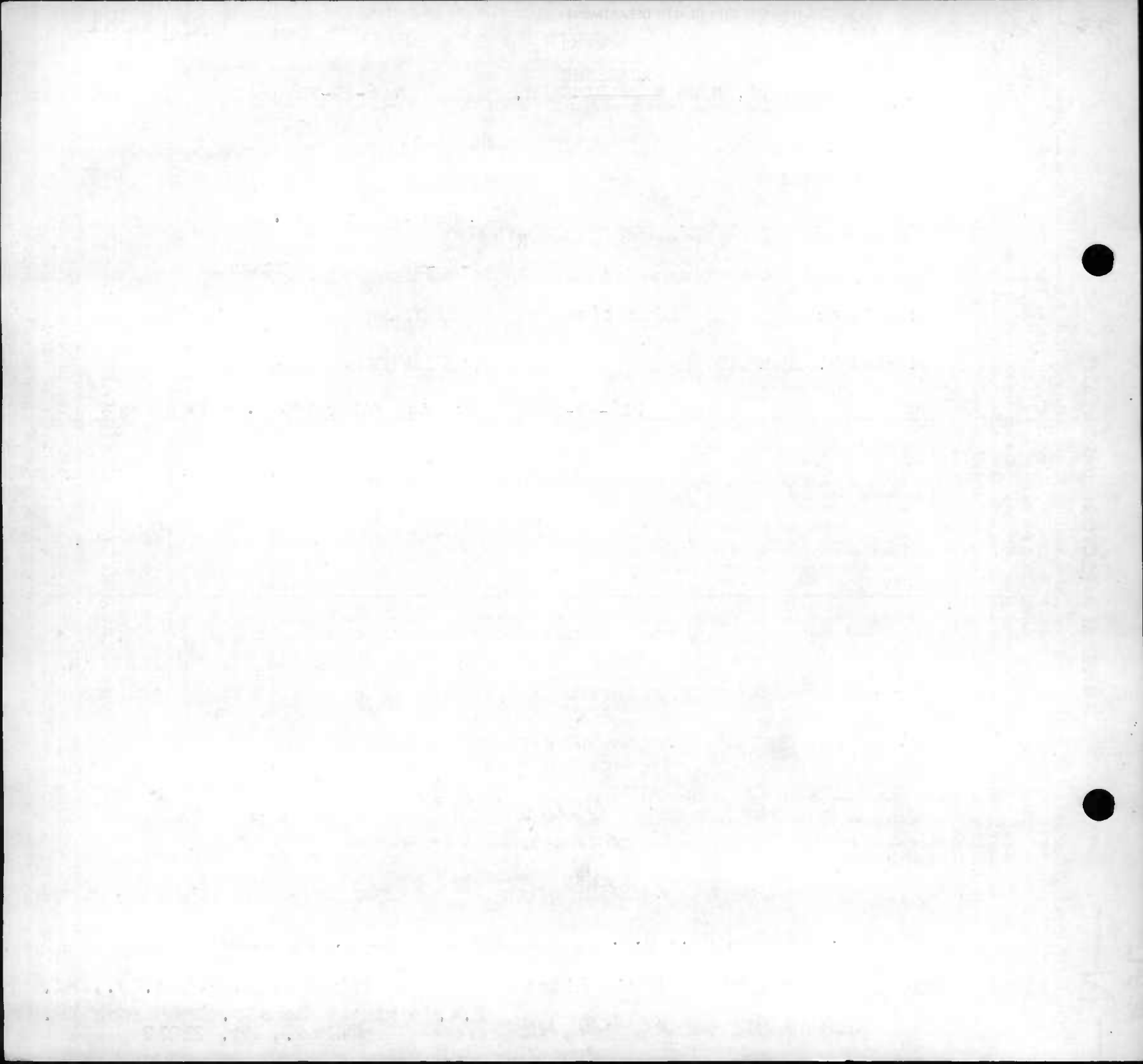
BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES A. TORP		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2524 Guilford Avenue		3. DATE PRONOUNCED DEAD Month Day Year June 28, 1972 9:30 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1203			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 2-21-1891		10. AGE (In years last birthday) 81 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balto... Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Torp		14. STREET AND NUMBER 2524 Guilford Avenue 21218	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Representative Burlington Mills		15. MOTHER'S MAIDEN NAME Schmidt	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-07-4532	
18. INFORMANT Mrs. Fred M. Miller		ADDRESS 500 Worcester Rd. 21204	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/28/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-72	
24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Jenkins, M.D.	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto. Md. 21212	

WALLACE

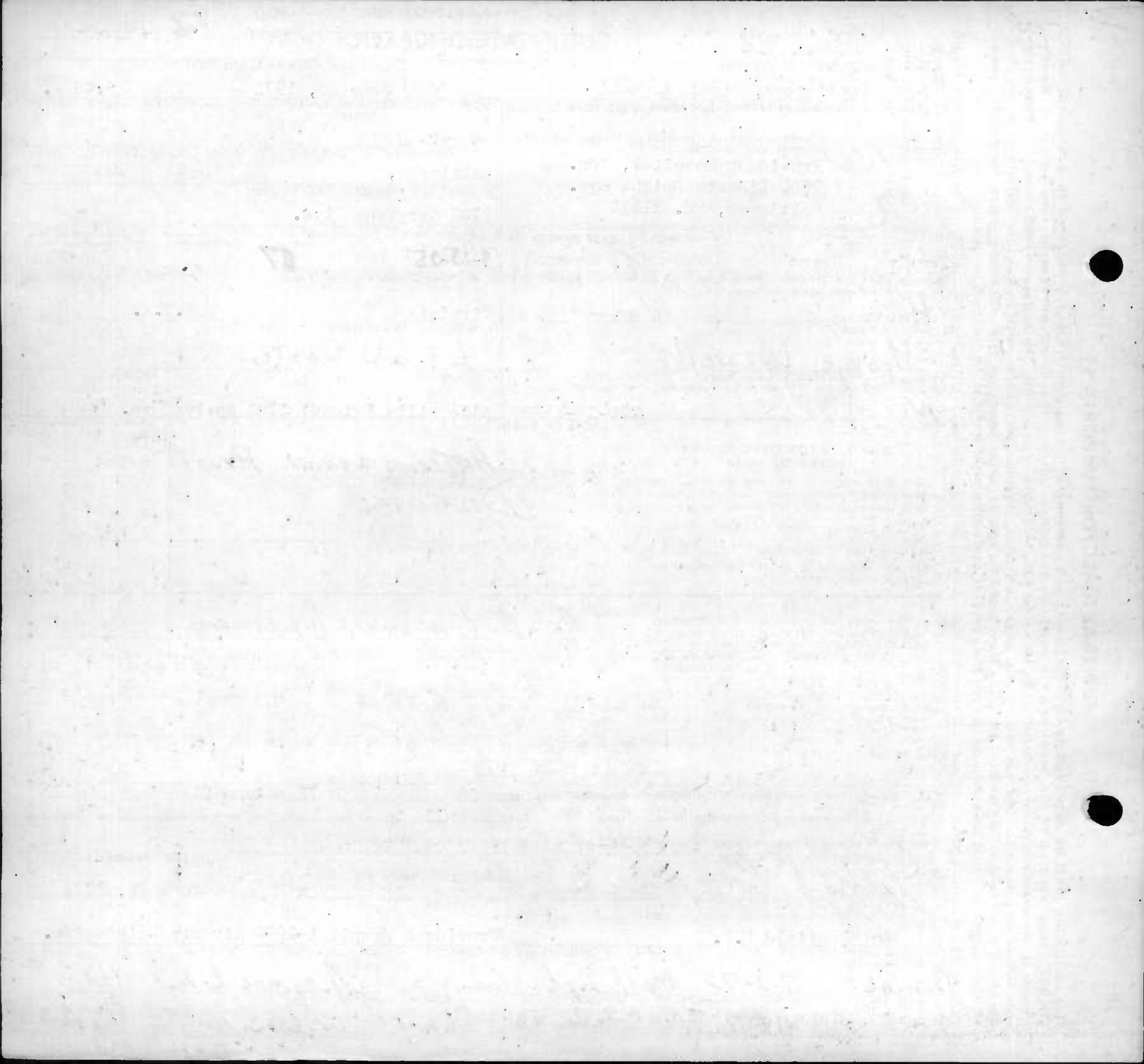
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06081	
CERTIFICATE OF DEATH					
BIRTH NO. 72 06081					
1. NAME OF DECEASED (Type or Print) MADELEINE THOMPSON, MISS MADELEINE M.		2. DATE AND HOUR OF DEATH 6-29-72 7:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD KESWICK HOMES		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 902			
FULL NAME OF HOSPITAL OR INSTITUTION 91 KESWICK HOMES		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5-23-92		9. AGE (In years last birthday) 80 years		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher		10B. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES M. THOMPSON		14. MOTHER'S MAIDEN NAME LOUISA FRANCES McCAULEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-44-0668		17. INFORMANT Keswick files 700 W. 40th street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Probable dissecting aneurysm of abdominal aorta		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerosis, generalized DUE TO, OR AS A CONSEQUENCE OF		Many years	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus				30 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that he (this hospital) attended the deceased from 12/31/69 19 to 6/29/72 19, that (I) we last saw the deceased alive on 6/29/72 19 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) we (did) not view the body after death.					
23A. SIGNATURE W.B. Daniels, Jr. M.D.		23B. DATE SIGNED 6/29/72		23C. PHYSICIAN'S NAME (Type) WORTH B. DANIELS, MR., M.D.	
23D. ADDRESS KESWICK 700 W. 40th Street		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/1/72		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR Robert E. Fabry, R.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 06082</u>	
BIRTH NO. <u>72 06082</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Turlington, Minnie Carter</u>			2. DATE AND HOUR OF DEATH <u>June 28, 1972</u> <u>5:45 a. m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital, Inc.</u> <u>2600 Liberty Height Ave.</u> <u>Baltimore, Md. 21215</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1538</u> C. CITY OR TOWN <u>Baltimore,</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2702 Garrison Blvd.</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-05</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Wessells</u>			14. MOTHER'S MAIDEN NAME <u>Laura Carter</u>		
15. Was Deceased <u>No</u> War in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-24-8120</u>	17. INFORMANT <u>Ella Mills (Niece) 2702 Roslyn Ave.</u>		
18. <u>4-12-31</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Heart Disease</u> <u>Acute Myocardial Insufficiency</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 28</u> 19 <u>72</u> to <u>June 28</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>June 28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>G. Banfield M.D.</u>			23B. DATE SIGNED <u>June 28, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>G. Banfield M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>7-2-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>McThompkins Cem.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1972</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>		25C. FUNERAL DIRECTOR <u>Elmer Og Wilson</u>
			25D. LOCATION (City, town, or county) <u>Accomac Co. VA.</u>		25E. ADDRESS <u>1000 Brantley Ave. Balto. Md.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06083		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06083	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CAMPBELL, Edward		June 24, 1972 4:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202		Md C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 808 St. Paul Street	
5. SEX M	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/29/00	9. AGE (In years last birthday) 71	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) unk.	
13. FATHER'S NAME unk.		14. MOTHER'S MAIDEN NAME unk.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-54-3739-T		17. INFORMANT Mrs. Julia Perle 808 St. Paul St. 21202	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Artery Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Senility (C) Prolonged Blindness		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 7, 1971 to June 24, 1972 that (I) (we) last saw the deceased alive on June 24, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE William D. Apperly		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) William D. Apperly	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-1972		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR P. E. Taylor, Jr.		25C. FUNERAL DIRECTOR 1735 Harford Ave. 21218 Marshall W. Jones, Jr.	

7/7/71 - Adm.

Crownsville state Hosp prev. address.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LUTHER BUTLER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year June 22, 1972 Hour 6:29 P.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 802	
9. DATE OF BIRTH 5-9-27		10. AGE (In years lost birthday) 45	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Thomas Butler		14. STREET AND NUMBER 1970 N. Patterson Park Avenue	
15. MOTHER'S MAIDEN NAME Mary Butler		16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Minnie McClam	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		20. ADDRESS 2619 Beryle Ave 21213	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Tuberculosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) DATE SIGNED 6/23/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Transit-burial		24B. DATE 6-28-1972	
24C. NAME of CEMETERY or CREMATORY Rock Hill Bapt. Cemetery		24D. LOCATION (City, town, or county) (State) Kingstree, South Carolina	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972		25B. NAME OF REGISTRAR P. E. Jones, Jr.	
25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.		ADDRESS 1735 Harford Ave 21213	

2-6-37

South Carolina

Laurens

Thomas Butler

Harry Butler

Mrs. Thomas Butler 2012 Laurel Ave. S.E.

MAILED
FEB 10 1937
U.S. DEPT. OF JUSTICE

Transit-Postal 4-22-1937
1725 Laurel Ave. S.E.
Laurens, South Carolina

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 02 06085	
BIRTH NO. 72 06085		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Robert Law		2. DATE AND HOUR OF DEATH 6/25/72 10:35 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY WASH DC	
		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 4003 Roland Ave. Bal. 11, MD	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-5-07
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) 64
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Law		14. MOTHER'S MAIDEN NAME Maud	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	17. INFORMANT -
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) abdominal aneurysm		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION -	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20A. AUTOPSY? (Yes or No) -	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 6-24-72 to 6-25-72 , that (I) (we) last saw the deceased alive on 6-25-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Shassan Khanij		23B. DATE SIGNED 6-25-72	
23C. PHYSICIAN'S NAME (Type) R. Doyle		23D. ADDRESS U. M. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL	24B. DATE 6/28/72	24C. NAME OF CEMETERY or CREMATORY YOUNG BOKERS U.	24D. LOCATION (City, town, or county) (State) 709 N. Wolfe St
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1972	25B. NAME OF REGISTRAR Ph. R. E. Fabe, MD	25C. FUNERAL DIRECTOR R. J. CURRAN - Towson, MD	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Miss Marie Vinci

2. DATE AND HOUR OF DEATH

6/28/72, 8:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mayland General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MD

CITY

1604

C. CITY OR TOWN

CITY

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1908 Edmondson Ave 21228

5. SEX

F

6. RACE

W

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

2/9/08

9. AGE (In years
last birthday)

64

If Under 1 Yr.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)retired
school teacher

10B. KIND OF BUSINESS OR INDUSTRY

Balto City Schools

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Late Salvator Vinci

14. MOTHER'S MAIDEN NAME

Late Concetta

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

21228

ADDRESS

Mr. Robert Vinci, 1908 Edmondson Avenue

18. 209 X I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Hemiplegia - generalized

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerotic Arteriosclerosis

(C) DUE TO, OR AS A CONSEQUENCE OF:

Myocardial Infarction

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

6/28

19

to

6/28

19

that (I) (we) last saw the deceased alive on

6/28

19

72

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

George C. Samaras MD

DEGREE

Attending ☐
Phys.Med. ☐
DirectorStaff ☒
Phys.

23B. DATE SIGNED

6/28/72

23C. PHYSICIAN'S
NAME (Type)

George C. Samaras MD

DEGREE

23D. ADDRESS

MOCT

24A. BURIAL CREMATION
REMOVAL (Specify)

Burial

24B. DATE

7/3/72

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 30 1972

25B. NAME OF REGISTRAR

P. R. E. J. J. J.

25C. FUNERAL DIRECTOR

Witzke, 1630 Edmondson Avenue 21228

ADDRESS

Intigral Journal of Mathematics

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1. Introduction
 2. Background
 3. Methodology
 4. Results
 5. Conclusion
 6. References
 7. Appendix
 8. Glossary
 9. Index
 10. Summary

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George C. Zarnett and
Marjorie C. Zarnett

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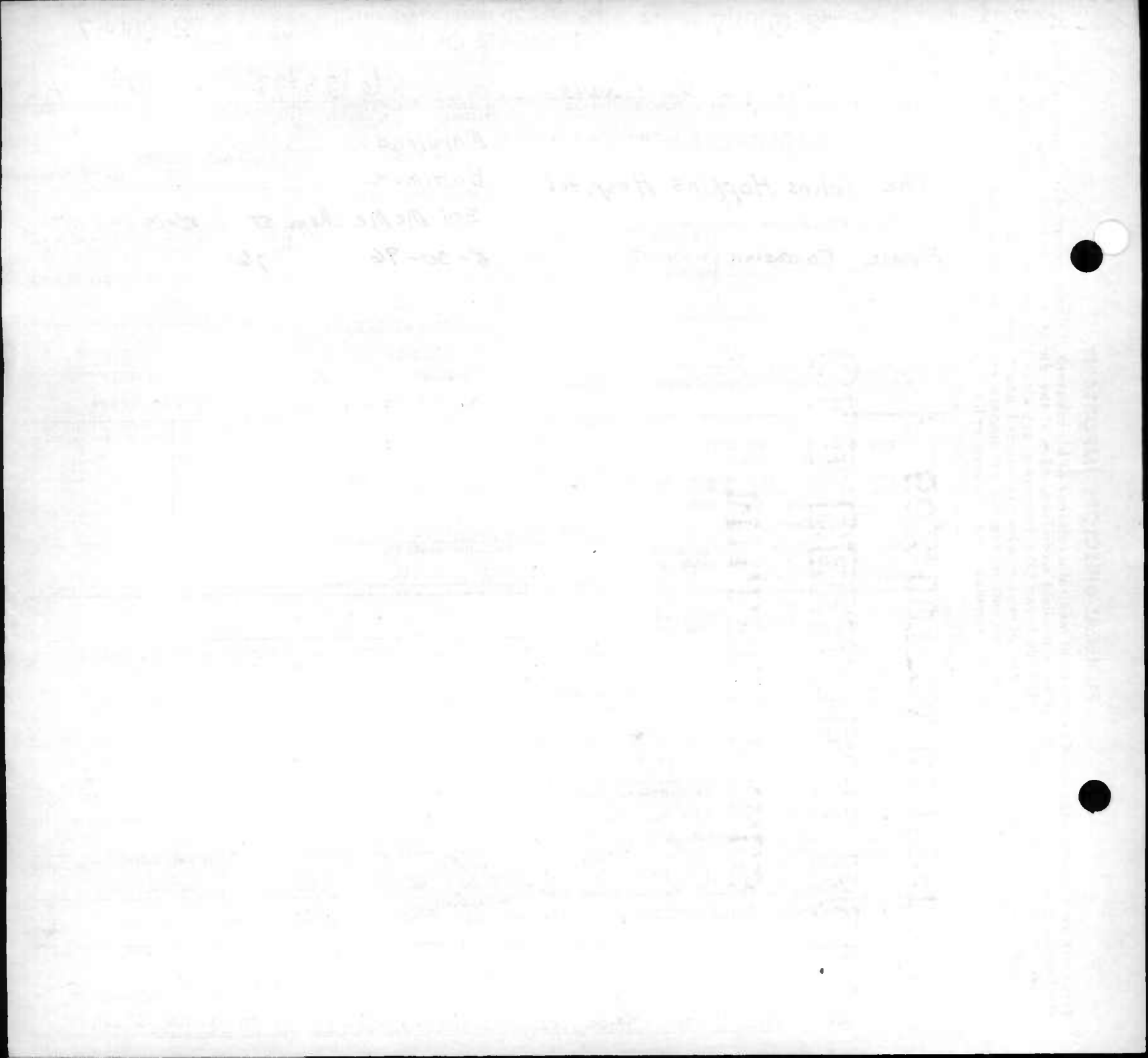
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

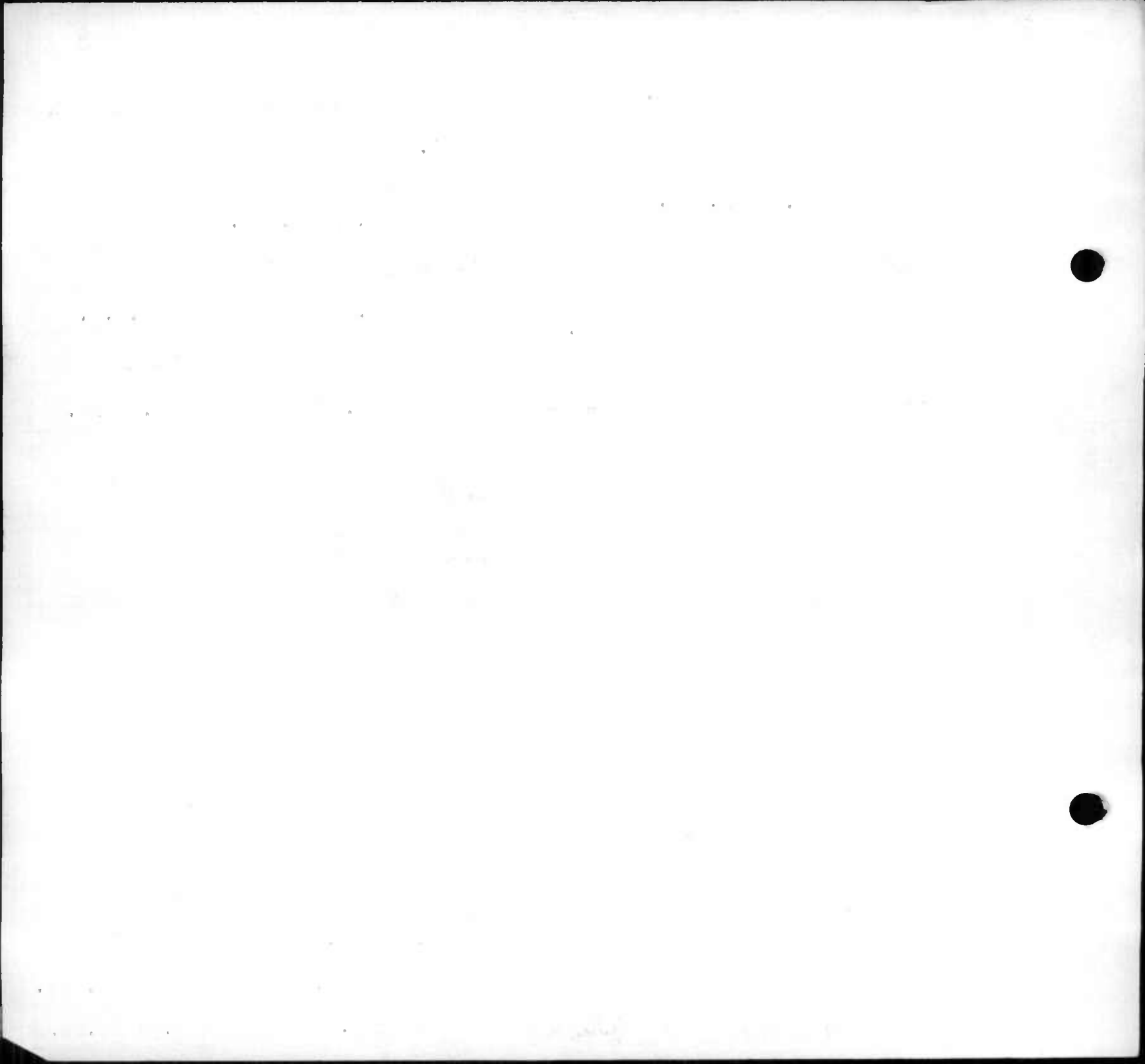
BALTIMORE CITY HEALTH DEPARTMENT				72 Q6087		72 Q6087	
CERTIFICATE OF DEATH				REG. NO.		72 Q6087	
1. NAME OF DECEASED (Type or Print) <u>Nannye V. Rawls</u>				2. DATE AND HOUR OF DEATH <u>6/28/72</u> <u>10³⁰</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1401</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>301 McMechen ST</u>		<u>Memorial Apts.</u>	
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-96</u>		9. AGE (in years last birthday) <u>76</u>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James Bosley</u>				14. MOTHER'S MAIDEN NAME <u>Grace Powley</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>21228</u> <u>Mr. Lee Rawls, 2025 Cedar Circle Drive</u>		
18. <u>180X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Probable hepatic failure</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>metastatic carcinoma</u> (B) <u>of cervix</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>of cervix</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>6/8/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>met. carcinoma</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1972</u> to <u>June 28, 1972</u> and that (I) (we) last saw the deceased alive on <u>June 28, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Wayne B. Leadbetter</u>						23B. DATE SIGNED <u>6/28/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Wayne Leadbetter, M.D.</u>						23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/30/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue</u>		25D. ADDRESS <u>21228</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

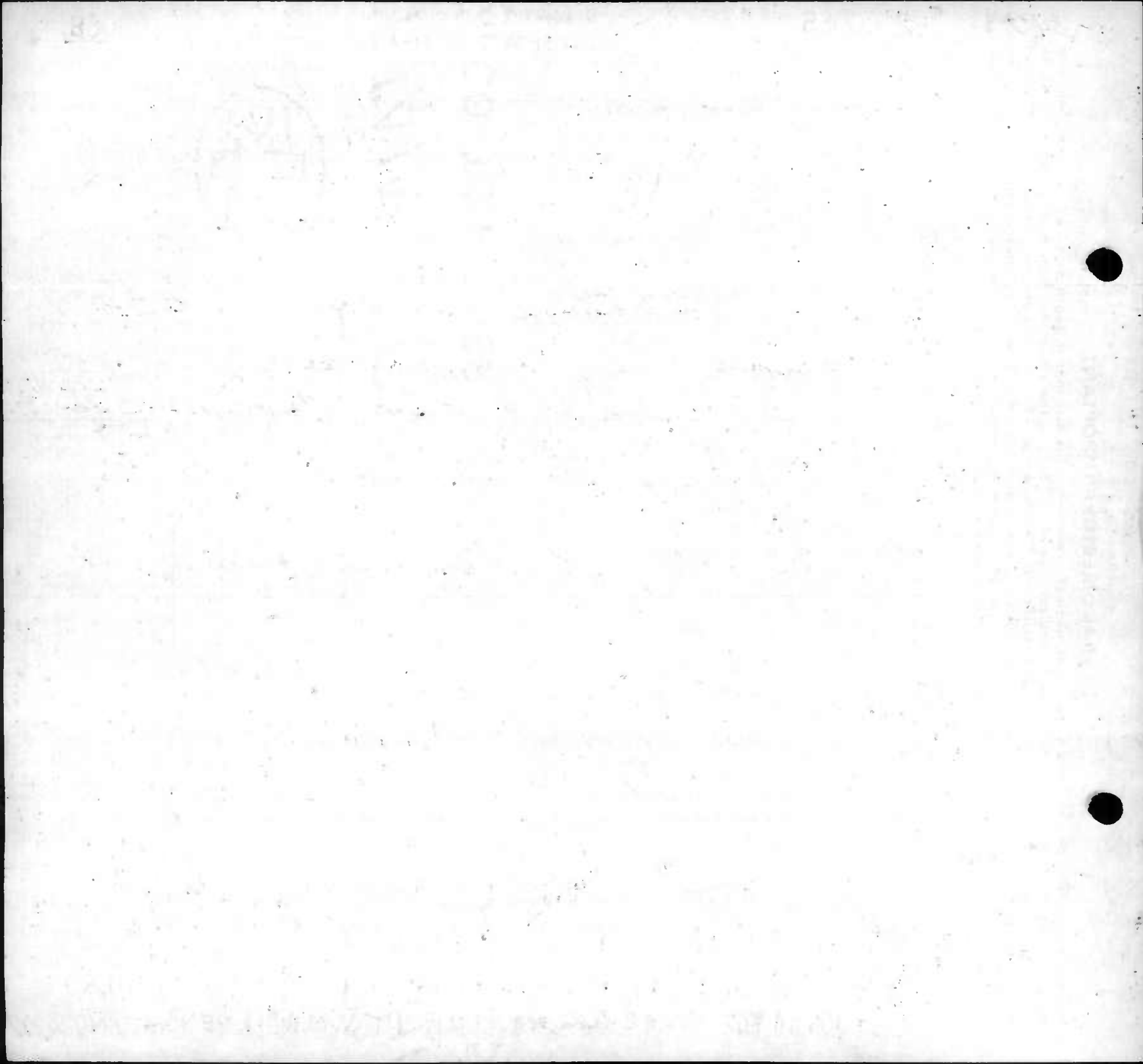
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 06088</u>	
BIRTH NO. <u>72 06088</u>					
1. NAME OF DECEASED (Type or Print) <u>Minnie E. Evans</u>		2. DATE AND HOUR OF DEATH <u>June 26, 1972</u> <u>1:45 P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 843 W. 36th. St.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1306</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>843 W. 36th. St.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-1879</u>	9. AGE (In years last birthday) <u>92</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hous Wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Erey</u>		14. MOTHER'S MAIDEN NAME <u>Larrimore</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-26-1750</u>		17. INFORMANT <u>Olive L. Thompson</u> ADDRESS <u>843 W. 36 St.</u>	
18. <u>440.1</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6-28-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-27</u> <u>1971</u> to <u>6-26</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>6-21</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>Reuben Hoffman, M.D.</u>		23B. DATE SIGNED <u>6-28-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Reuben Hoffman</u>		23D. ADDRESS <u>846 W. 36 St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/30/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Marvin Chapel</u>	
24D. LOCATION (City, town, or county) (State) <u>Mt. Airy, Carroll Co. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1972</u>		25B. NAME OF REGISTRAR <u>P. E. F. F. F.</u>		25C. FUNERAL DIRECTOR <u>Frank W. Seitz</u> ADDRESS <u>814 W. 36 St. Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

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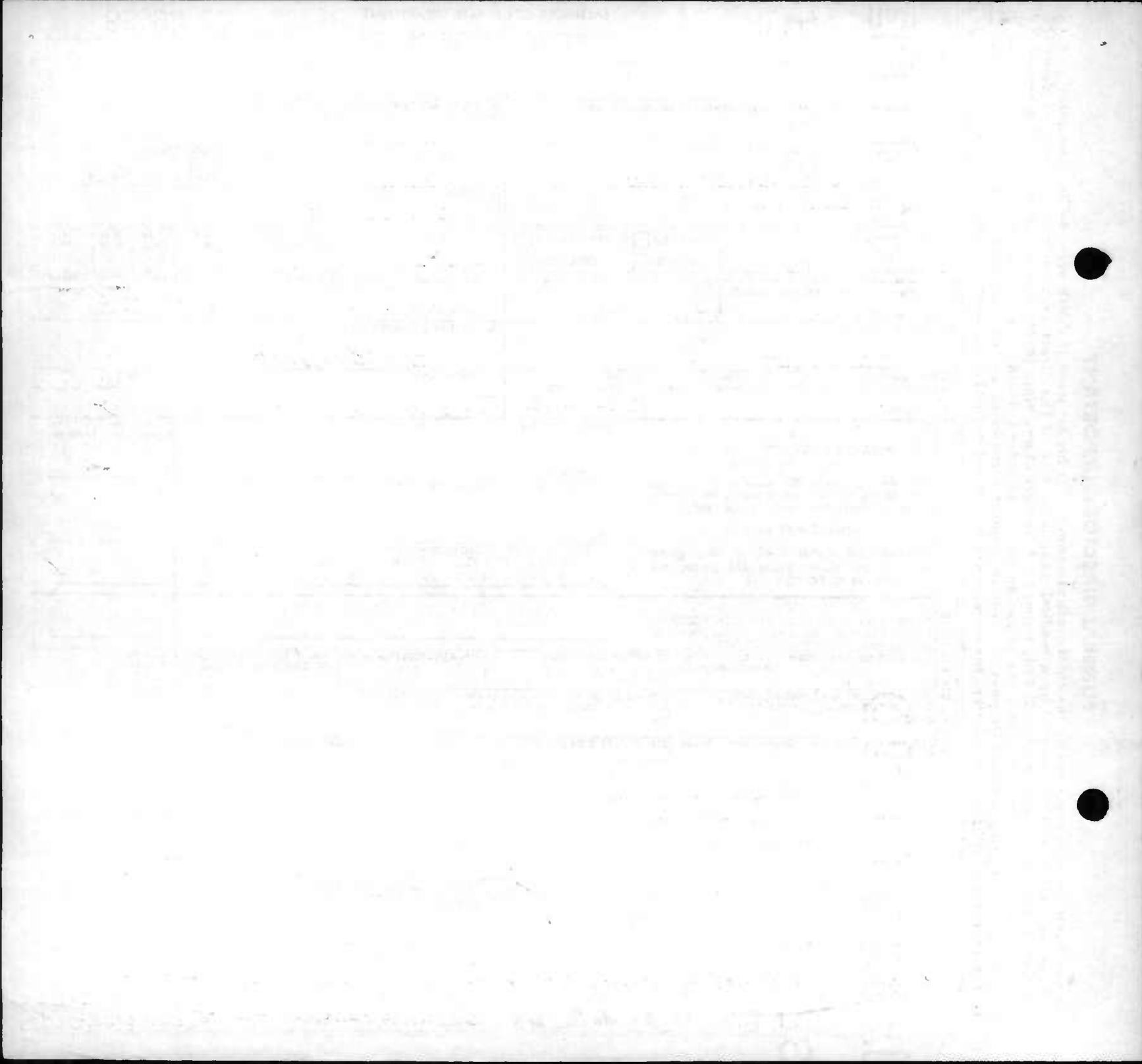
72 06089		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 72 06089	
BIRTH NO. <i>VOTEL</i>		1. NAME OF DECEASED (Type or Print) <i>Votek, Paul</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <i>6/27/72 7:05</i> M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Caton Manor Nursing home W. L. Kous + Caton Avenue</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore</i> B. COUNTY <i>Harford</i> C. CITY OR TOWN <i>Box # 111, Pasadena, Md.</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-6-1894</i>		9. AGE (In years last birthday) <i>88?</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SEAMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>WATERMAN SELF-EMPLOYED</i>		11. BIRTHPLACE (State or foreign country) <i>GERMANY</i>	
13. FATHER'S NAME <i>UNOBTAINABLE</i>		14. MOTHER'S MAIDEN NAME <i>UNOBTAINABLE</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>200-46-9161</i>		17. INFORMANT <i>ROBERT W. WATERS, 157 N. Frederick St.</i>	
18. <i>4-12-41-1894-X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH A. IMMEDIATE CAUSE <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of Prostate gland</i> B. DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic renal disease + Azotemia</i> C. <i>year</i> <i>6 mos</i> <i>6 mos</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/9</i> 19 <i>72</i> to <i>6/27</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>6-2</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. A. Schumacher, M.D.</i>				23B. DATE SIGNED <i>6-27-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>W. A. Schumacher, M.D.</i>				23D. ADDRESS <i>7935 Pipers Path Sea Breeze Md 21061</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1 JULY 72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>OAK LAWN CEMETERY</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, COUNTY MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1972</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>ULLRICH FUNERAL HOME BALTO. MD. 21206</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 Q6090		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 Q6090	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) STEWART KIRTZ		2. DATE AND HOUR OF DEATH 6/27/72 11:03 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2634			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 02-18-02 9. AGE (In years last birthday) 70		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10B. KIND OF BUSINESS OR INDUSTRY AUTO MEX.		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME WILLIAM KIRTZ			
14. MOTHER'S MAIDEN NAME ZINA BUCHANAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-10-4767	
17. INFORMANT THEODORE KIRTZ		ADDRESS 21222			
18. 591X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE HYPERKALEMIA DUE TO, OR AS A CONSEQUENCE OF: RENAL FAILURE			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: HYDRONEPHROSIS, PROB. URETERAL STRICTURES (C) (B OF), ACUTE TUB. NECROSIS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		SEPSIS, SEIZURES, COMA, DEBILITATED STATE			
19A. DATE OF OPERATION 6/9/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RENAL FAILURE		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/17 19 72 to 6/27 19 72 that (I) (we) last saw the deceased alive on 6/27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce M. Greene		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/27/72	
23C. PHYSICIAN'S NAME (Type) BRUCE M. GREENE MD		23D. ADDRESS 601 N. BROADWAY BALTO, MD. 21205			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 30 June 72		24C. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY	
24D. LOCATION (City, town, or county) BALTO CO, MD.		24E. STATE (State) MD.			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR D. R. B. E. J. B. MD		25C. FUNERAL DIRECTOR CLERIGH FUNERAL HOME, DUNDALK, MD	
ADDRESS 21222					



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 06081

BIRTH NO. 72 06081		2. DATE AND HOUR OF DEATH 6-26-72 10:23 P.M.	
1. NAME OF DECEASED (Type or Print) EY, Albert Richard		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2005	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-10-99	
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pest Control Operator	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Ey		14. MOTHER'S MAIDEN NAME Margaret Clare	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4-17-17 to 1-29-19		16. SOCIAL SECURITY NO. 218-10-0850	
17. INFORMANT VA Hospital Records		ADDRESS Baltimore, Maryland 21218	
18. 427.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE / SHOCK ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Left ventricular failure - etiology undetermined		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Left ventricular failure - etiology undetermined (C) Cardiac arrhythmia - at. fib.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XI (this hospital) attended the deceased from June 20, 1972 to June 26, 1972 , that XI (we) lost saw the deceased alive on June 26, 1972 and that in XI (our) opinion death occurred on the date and hour and from the causes stated above. XI (We) (did) not view the body after death.			
23A. SIGNATURE Dan H. McDougal, MD		23B. DATE SIGNED 6/28/72	
23C. PHYSICIAN'S NAME (Type) Dan H. McDougal, M.D.		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-1972	
24C. NAME OF CEMETERY or CREMATORY Crest Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Howard County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Paul E. Taylor, MD	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave, 21229	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06092		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06092	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HARRY R. SMITH		June 27, 1972 6 20 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 42 N. Athol Avenue Baltimore, Maryland 21229			A. STATE Maryland 2864 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 42 N. Athol Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-1909	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Fitter		10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John H. Smith		
14. MOTHER'S MAIDEN NAME Ida B. Driscoll			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-05-5926			17. INFORMANT ADDRESS Mrs. Hilda H. Smith, 42 N. Athol Ave. 21229		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: Coronary left branch C. Myocardial infarction		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 1 year 2 years					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/11 1967 to 6/27 1972, that (I) (we) last saw the deceased alive on 10/4 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. W. Johnson M.D.				23B. DATE SIGNED 6/27/72	
23C. PHYSICIAN'S NAME (Type) E. W. Johnson				23D. ADDRESS 3432 Frederick Avenue, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-1972		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Wash. Blvd. Howard Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25D. ADDRESS			

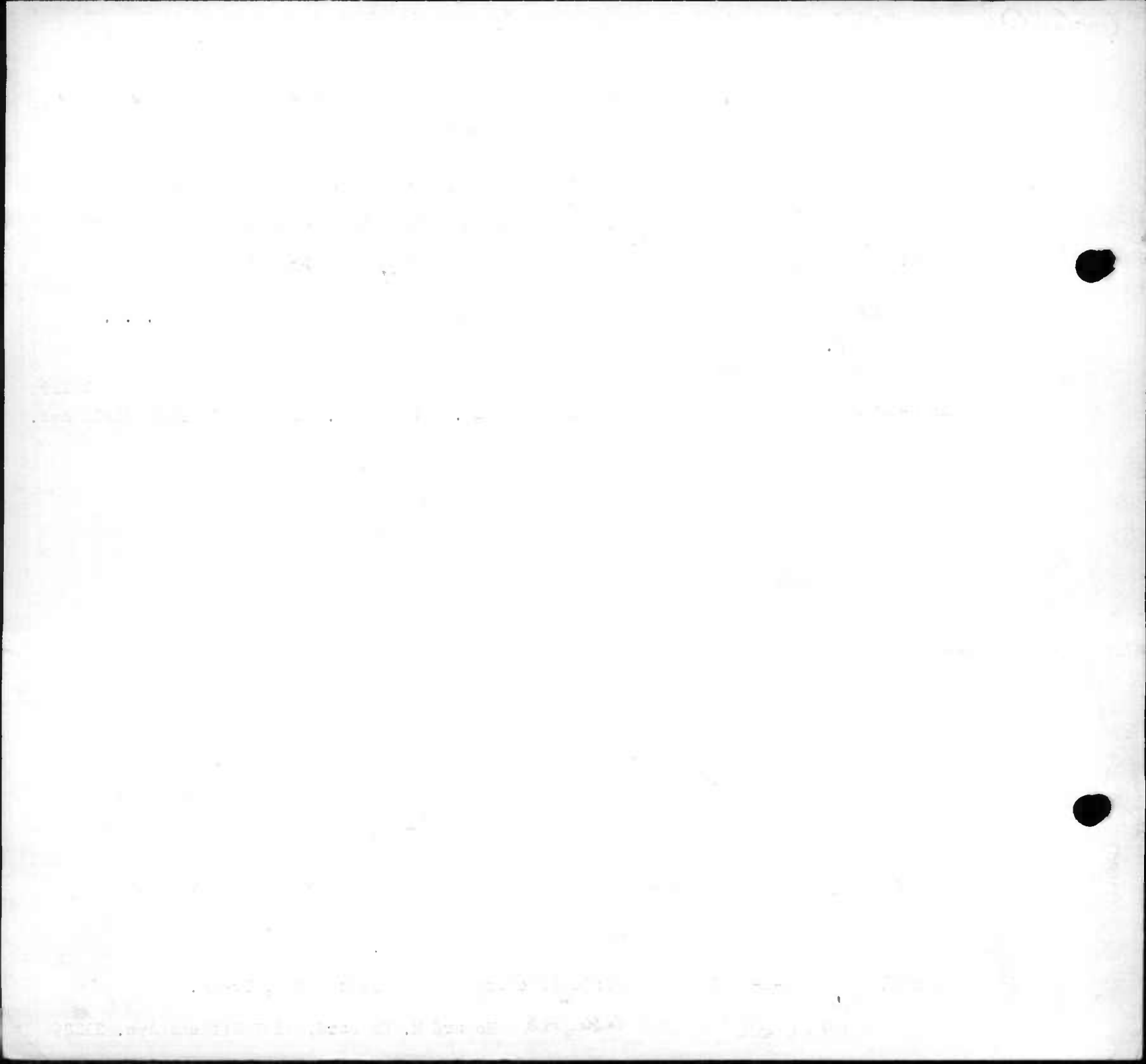
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

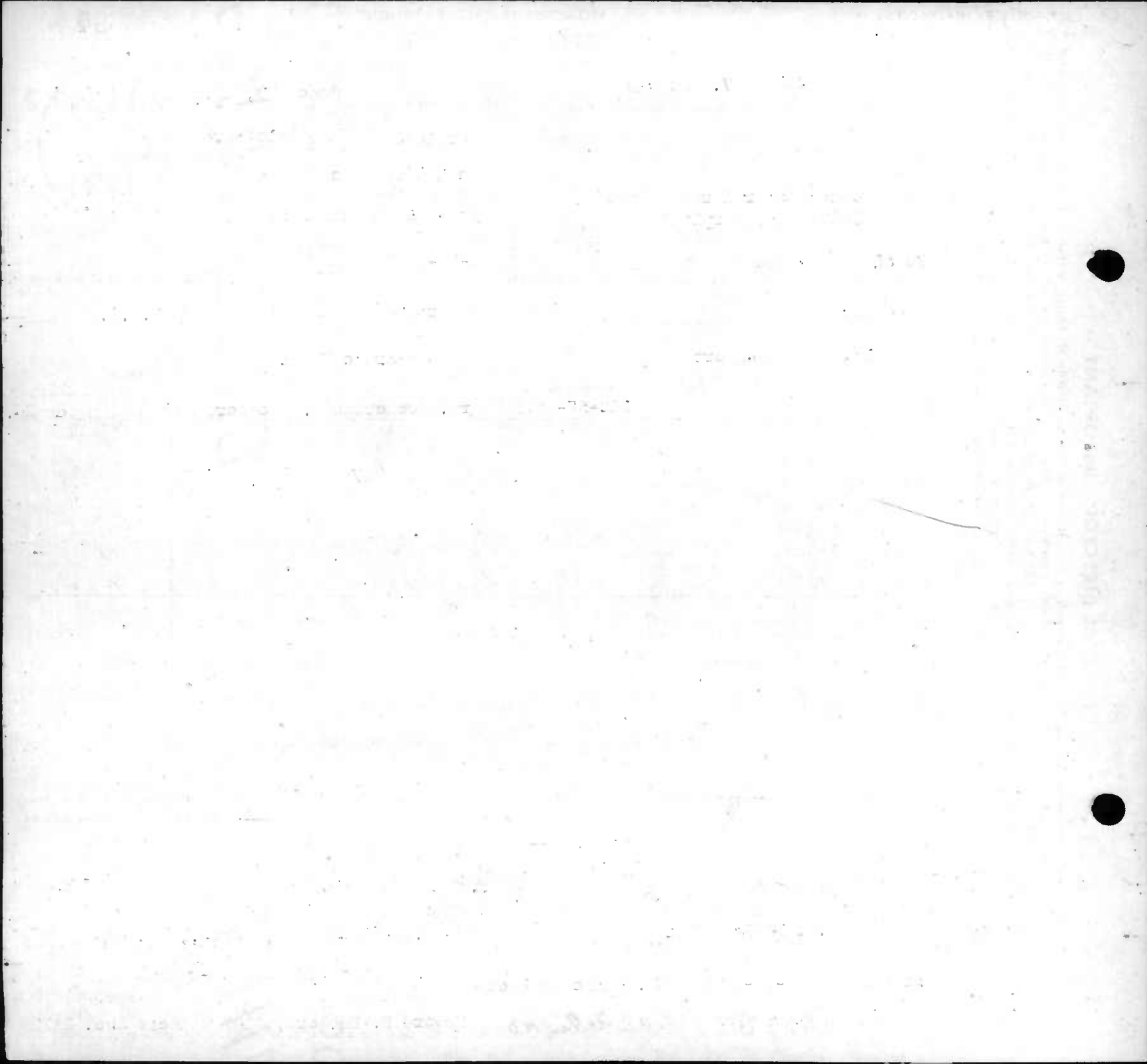
72 06093		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 145-284 72 06093	
BIRTH NO.			1. NAME OF DECEASED (Type or Print) <u>Grusch, Robert C</u>		
2. DATE AND HOUR OF DEATH <u>6-28-72</u> <u>11:25 A.M.</u>			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>34 Bon Secours Hospital</u>		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2541</u>			FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>34 Bon Secours Hospital</u>		
5. SEX <u>M</u>		6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01/31/14</u>	
9. AGE (in years last birthday) <u>58</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>J. HARRY GRUSCH</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Seidel</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>1945-1961</u>		16. SOCIAL SECURITY NO. <u>162-18-5512</u>		17. INFORMANT <u>Mrs. Margaret M. Grusch, 575 Beechfield Ave.</u>	
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>C.H.F.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic pulmonary disease</u>		
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes mellitus</u>			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-20</u> 19 <u>72</u> to <u>6-28</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6-28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Vilayan Thitivarana</u>			23B. DATE SIGNED <u>6-28-72</u>		23C. PHYSICIAN'S NAME (Type) <u>VILAIYAN THITIVARANA, M.D.</u>
23D. ADDRESS <u>B. S.H.</u>		24A. BURIAL CREATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>7-1-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Union Dale Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pittsburgh, Penna.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

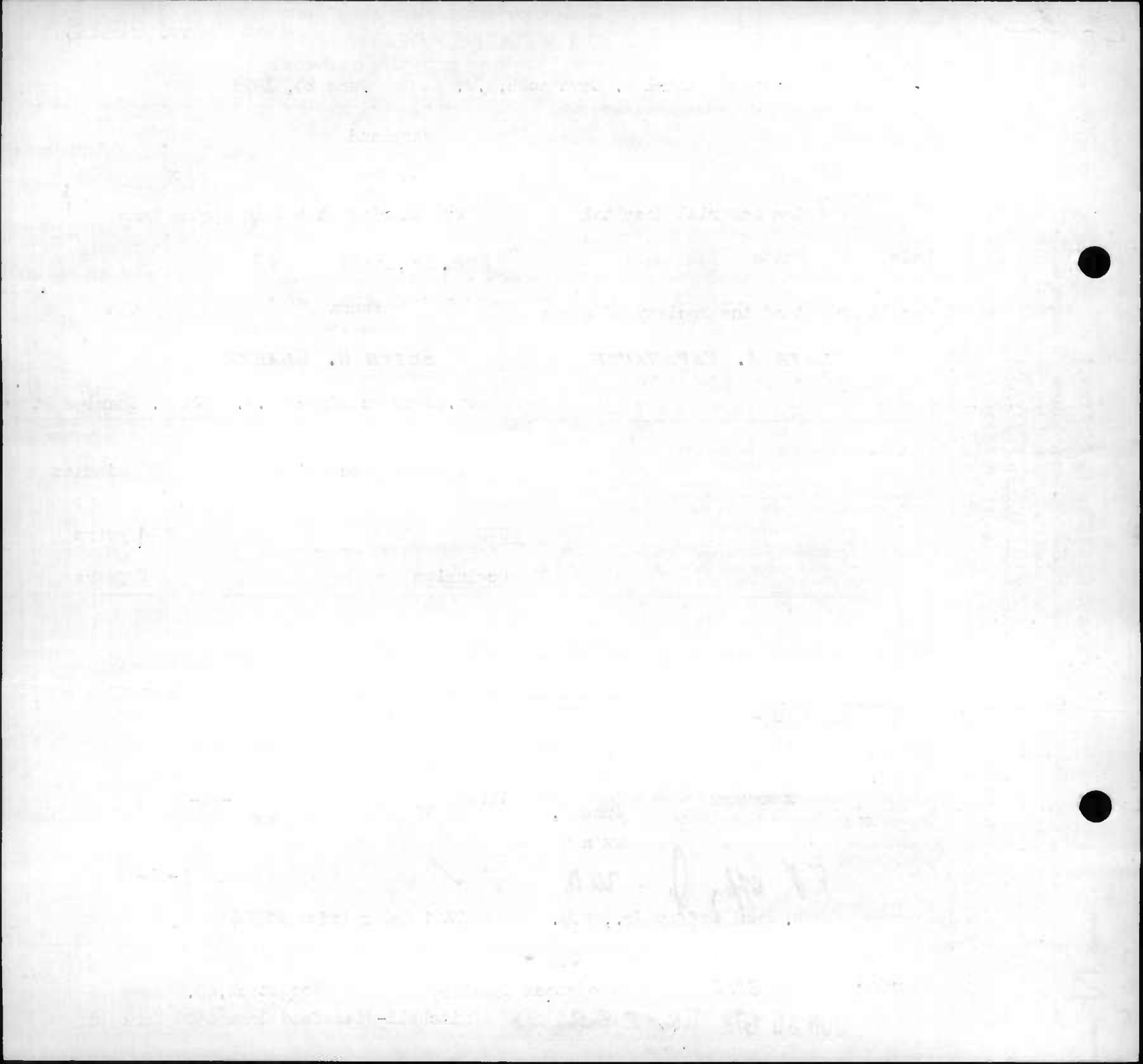
BALTIMORE CITY HEALTH DEPARTMENT									
72 06084					X		REG. NO. 72 06084		
BIRTH NO.					1. NAME OF DECEASED (Type or Print) LOTTA V. SCHONE				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					2. DATE AND HOUR OF DEATH June 27, 1972 1:15 A.M.				
FULL NAME OF HOSPITAL OR INSTITUTION 90 Caton Manor Nursing Home Baltimore, Maryland					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN West Edmondale		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 5444 Addington Road									
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-1883	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Buppert			14. MOTHER'S MAIDEN NAME Catherine Klohr						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-58-6657		17. INFORMANT Mrs. Catherine M. Kuebler, 5444 Addington Rd.				ADDRESS 21229
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarct					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 hrs.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Congestive heart failure					(B) DUE TO, OR AS A CONSEQUENCE OF: 5 years				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Colostomy					(C) A.S.C.V. disease		15 yrs.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 1967 to June 27 1972 , that (I) was lost saw the deceased alive on June 14 1972 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.									
23A. SIGNATURE D.C. MacLaughlin					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 6/27/72	
23C. PHYSICIAN'S NAME (Type) D.C. MacLaughlin					23D. ADDRESS 303 N. Rolling Road, Balto., Md. 21228				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-1972		24C. NAME OF CEMETERY or CREMATORY Mt. Olive Cemetery		24D. LOCATION (City, town, or county) (State) Randallstown, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR R. E. Fisher, Jr.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

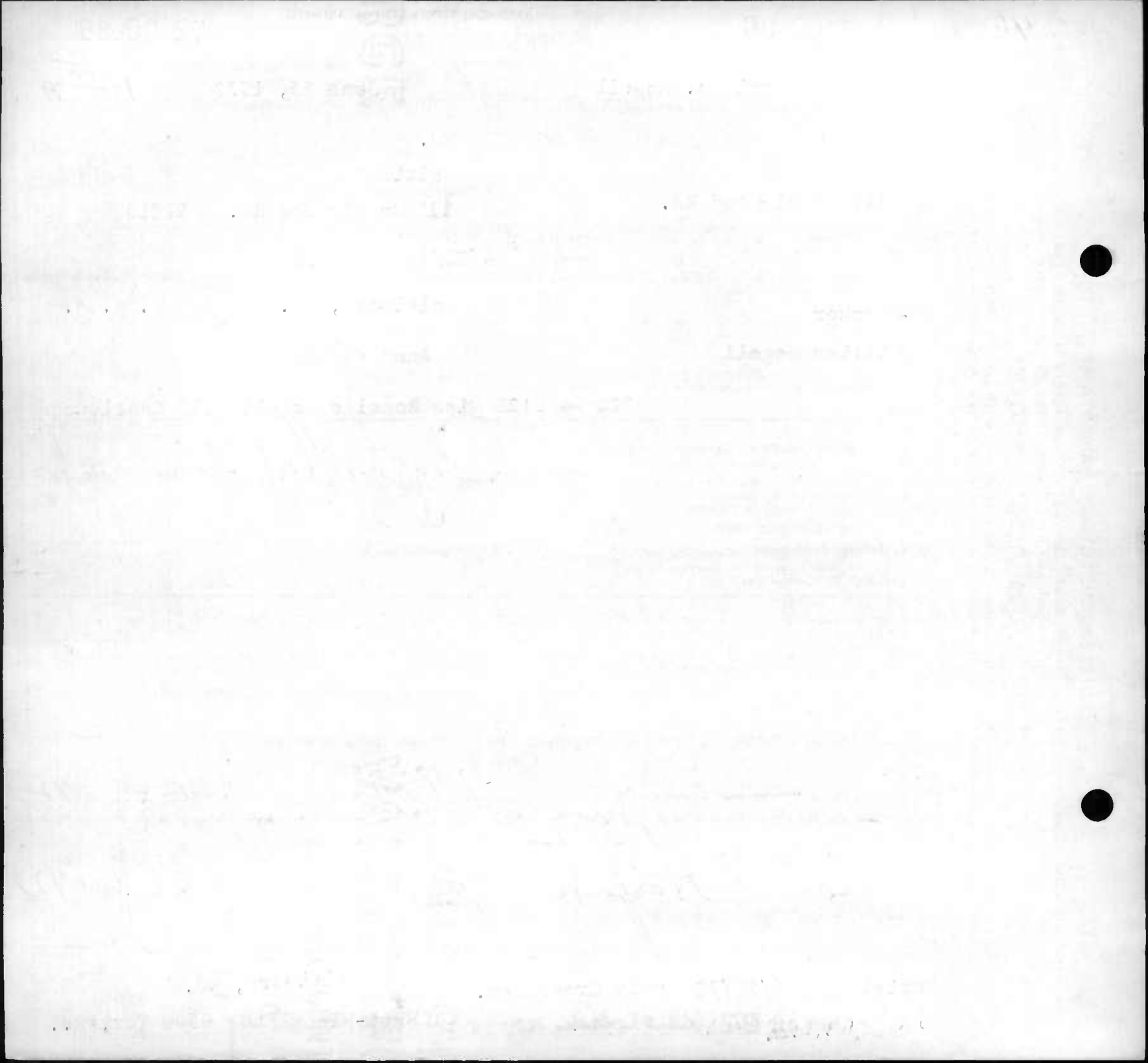
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 06095</u>	
BIRTH NO. <u>72 06095</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Reverend Daniel E. Cavanaugh, S.J.		June 24, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44</u> Union Memorial Hospital		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2711</u> Charles St & Cold Spring Lane			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1924	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jesuit Priest of the		10B. KIND OF BUSINESS OR INDUSTRY Society of Jesus		11. BIRTHPLACE (State or foreign country) Penna	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CLAIR A. CAVANAUGH		14. MOTHER'S MAIDEN NAME EDITH M. CLARKE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Rev. James McAndrews S.J. 4501 N. Charles St	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF: (B) ACVD DUE TO, OR AS A CONSEQUENCE OF: (C) Old Occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 10 years 8 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) did not attended the deceased from <u>1962</u> to <u>6-24-72</u> that (I) one last saw the deceased alive on <u>June 9,</u> 19 <u>72</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death.					
23A. SIGNATURE <u>E. Paul Coffay Jr.</u> M.D.		23B. DATE SIGNED 6-26-72		23C. PHYSICIAN'S NAME (Type) E. Paul Coffay Jr., M.D.	
23D. ADDRESS 7401 Osler Drive 21204		23E. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd		23F. ADDRESS Woodstock, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/72		24C. NAME OF CEMETERY or CREMATORY Woodstock Cemetery	
24D. LOCATION Woodstock, Md.		24E. DATE REC'D BY HEALTH DEPT. JUN 30 1972		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

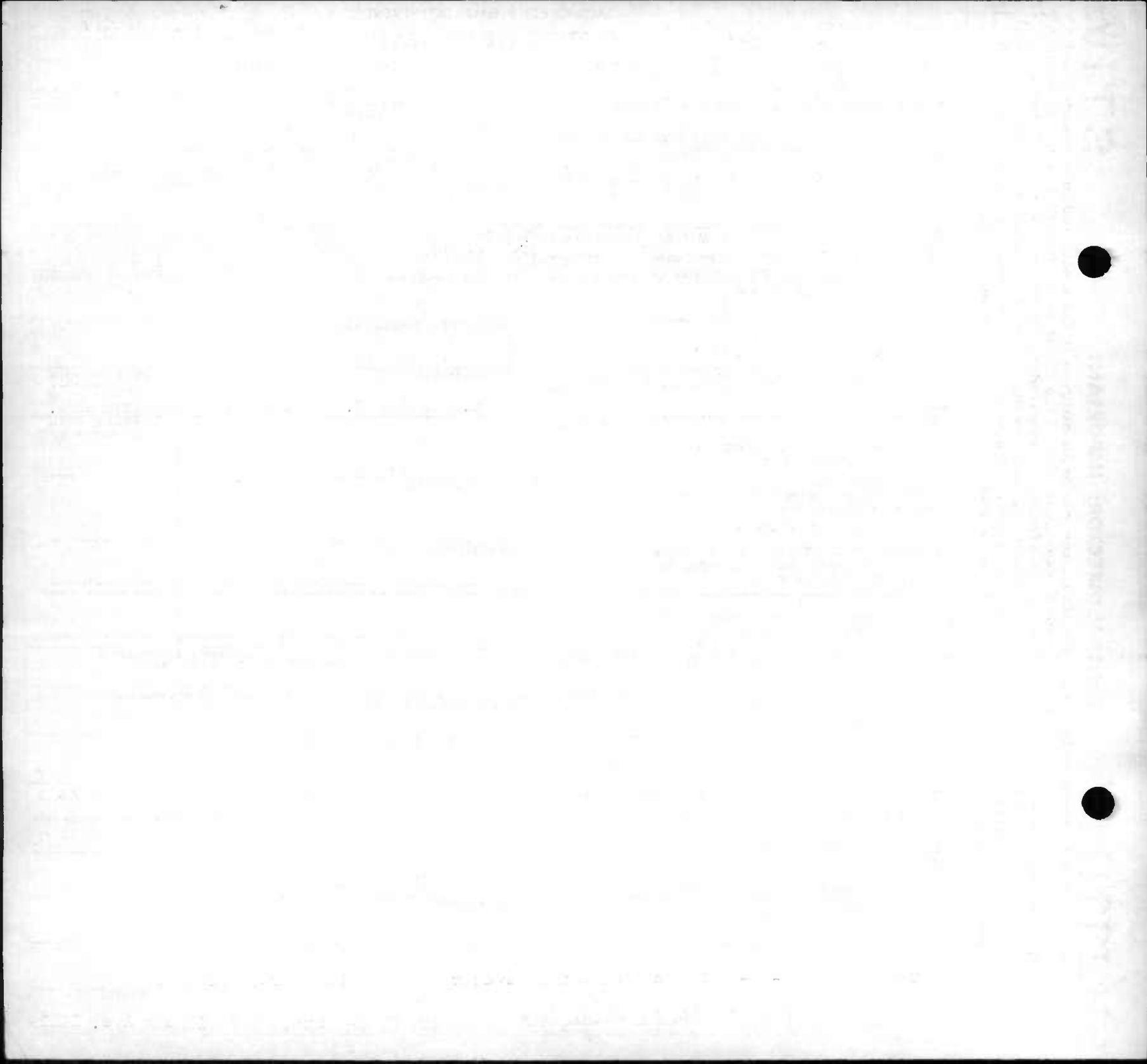
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06096	
BIRTH NO. 72 06096		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Marie A. Nagell		2. DATE AND HOUR OF DEATH June 25, 1972 11:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 115 Castlewood Rd.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2712	
5. SEX F		6. RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/23/1888	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		9. AGE (In years last birthday) 83	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME William Nagell		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220 44 0125	
17. INFORMANT Miss Rosella Nagell		ADDRESS 115 Castlewood	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 427.0 Digestive Heart Failure 24 hrs.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Digestive Heart Failure 24 hrs. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1955 to June 25, 1972 , and that (I) (we) last saw the deceased alive on June 24, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Wm L. Helmer		23B. DATE SIGNED 26 June 72	
23C. PHYSICIAN'S NAME (Type) Wm L. Helmer		23D. ADDRESS Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/72	
24C. NAME OF CEMETERY or CREMATORY Holy Cross Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Helmer, Jr.	
25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD		ADDRESS 6500 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

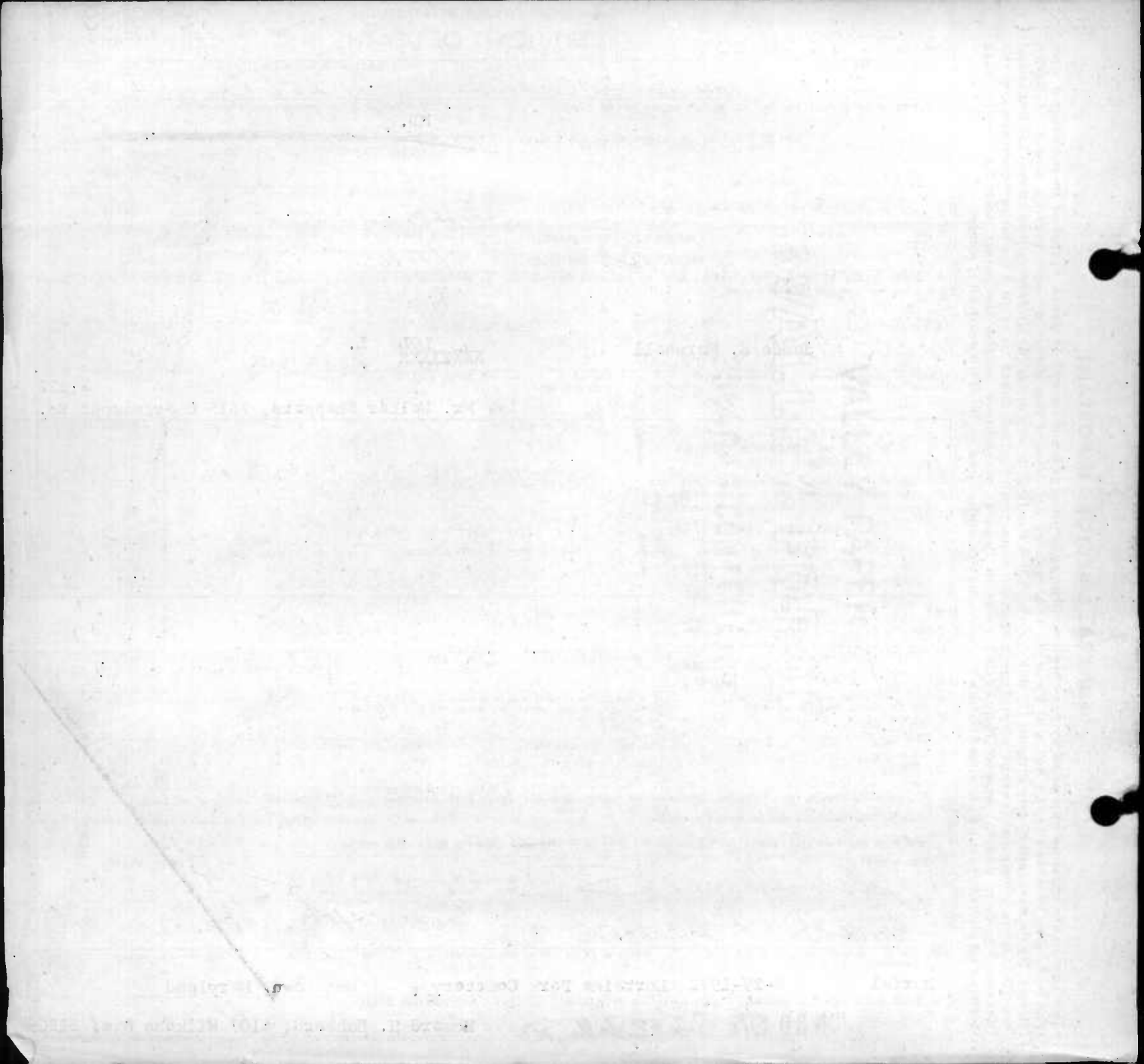
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										
BIRTH NO. <u>72-06097</u>					REG. NO. <u>72 06097</u>					
1. NAME OF DECEASED (Type or Print) <u>JENNIFER ANNE COLGAN</u> <u>Baby Girl Colgan</u>					2. DATE AND HOUR OF DEATH <u>6/25/72</u> <u>11:04 A.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore Gen. Hospital</u> <u>43</u>					A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>LANSOWNE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
					E. STREET AND NUMBER <u>614 Washington Ave</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/72</u>	9. AGE (in years last birthday)	10. UNDER 1 Yr. Months Days	11. UNDER 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stanley J. Colgan</u>					14. MOTHER'S MAIDEN NAME <u>Catherine M. Colson</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Stanley J. Colgan, 614 Washington Ave.</u>				ADDRESS <u>21227</u>	
18. <u>772X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>IMMATURITY</u>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> 19 <u>72</u> to <u>6/25</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6/25</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Elmer L. Hubbard</u> M.D. DEGREE						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/25/72</u>		
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>						24B. DATE <u>6-27-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		
24D. LOCATION <u>Baltimore, Maryland</u>										
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1972</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, RD</u>			25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave., 21229</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06098	
BIRTH NO. 72 06098				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) LILY FRANCIS SHEPPARD			2. DATE AND HOUR OF DEATH 6/25/72 4:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTO. GEN. HOSP. 3001 S. HANOVER ST.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2525 CHRISTIAN ST.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/05	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H/W		10B. KIND OF BUSINESS OR INDUSTRY Wife	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME (DEC) James E. Marshall			14. MOTHER'S MAIDEN NAME LOLA L. RITCHIE (Dec)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-20-3338	17. INFORMANT Mr. Walter Sheppard, 7615 Charlesmont Rd. ADDRESS 21222		
18. 157.9 17250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIAB. MELLITUS.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARRHYTHMIA (B) RENAL, PULMONARY FAILURES DUE TO, OR AS A CONSEQUENCE OF: Dis function (C) Ca of PANCREAS 6 hr. 2 Days 6 month > 2 hr.		
19A. DATE OF OPERATION 6/22/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MOOR	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (N) (this hospital) attended the deceased from 6/14/72 1972 to 6/25/72 1972 that (I) (we) last saw the deceased alive on 6/25 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 6/25/72		
23C. PHYSICIAN'S NAME (Type) NAPOLEON P. ABAJIDO MD			23D. ADDRESS 3001 S. HANOVER ST. MD		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	6-29-1972	Lorraine Park Cemetery	Woodlawn, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Hubbard	25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave/ 21229		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 06098		72 06098	
BIRTH NO. 72 06098				CERTIFICATE OF DEATH		REG. NO. 72 06098	
1. NAME OF DECEASED (Type or Print) CHANCE, THOMAS R., JR.				2. DATE AND HOUR OF DEATH June 26, 1972 1:50 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 23 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 8307 Edgedale Rd.			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-21	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: 5 300	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician			10B. KIND OF BUSINESS OR INDUSTRY Herger Cons. Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Thomas R. Chance Sr.				14. MOTHER'S MAIDEN NAME Elva Jacobs			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8-27-42 to 12-10-45				16. SOCIAL SECURITY NO. 215-16-5219		17. INFORMANT V. A. Hospital ADDRESS 3900 Loch Raven Blvd., Baltimore, Md. 21218	
18. 425X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiogenic Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cardiomyopathy				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic Failure (B) DUE TO, OR AS A CONSEQUENCE OF: Cardiomyopathy (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 17, 1972 to June 26, 1972 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June 26, 1972 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE M. B. Pearlman MD				23B. DATE SIGNED 6/28/72			
23C. PHYSICIAN'S NAME (Type) M. B. PEARLMAN				23D. ADDRESS Loch Raven UAM			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Feltz, Jr.		25C. FUNERAL DIRECTOR ADDRESS John C. Mibler Inc-415 Belair Rd.-21206			

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72 06100

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06100

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Eton Karl Albert Jurjeleit		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 6 Day 1 Year 72 Hour 9:35 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 18 W. West Street		3. DATE PRONOUNCED DEAD Month 6 Day 1 Year 72 Hour 9:35 a. M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH unknown		10. AGE (in years lost birthday) 42	
11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? unknown	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown		17. SOCIAL SECURITY NO. 061362249	
18. INFORMANT Edward Glover 1020 S. Charles St		19. ADDRESS 1116 W. Cross St	

19. CAUSE OF DEATH E966X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Stabwound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 18 W. West Street	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 5/31/72 7:00 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject was stabbed by unknown assailant.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)					

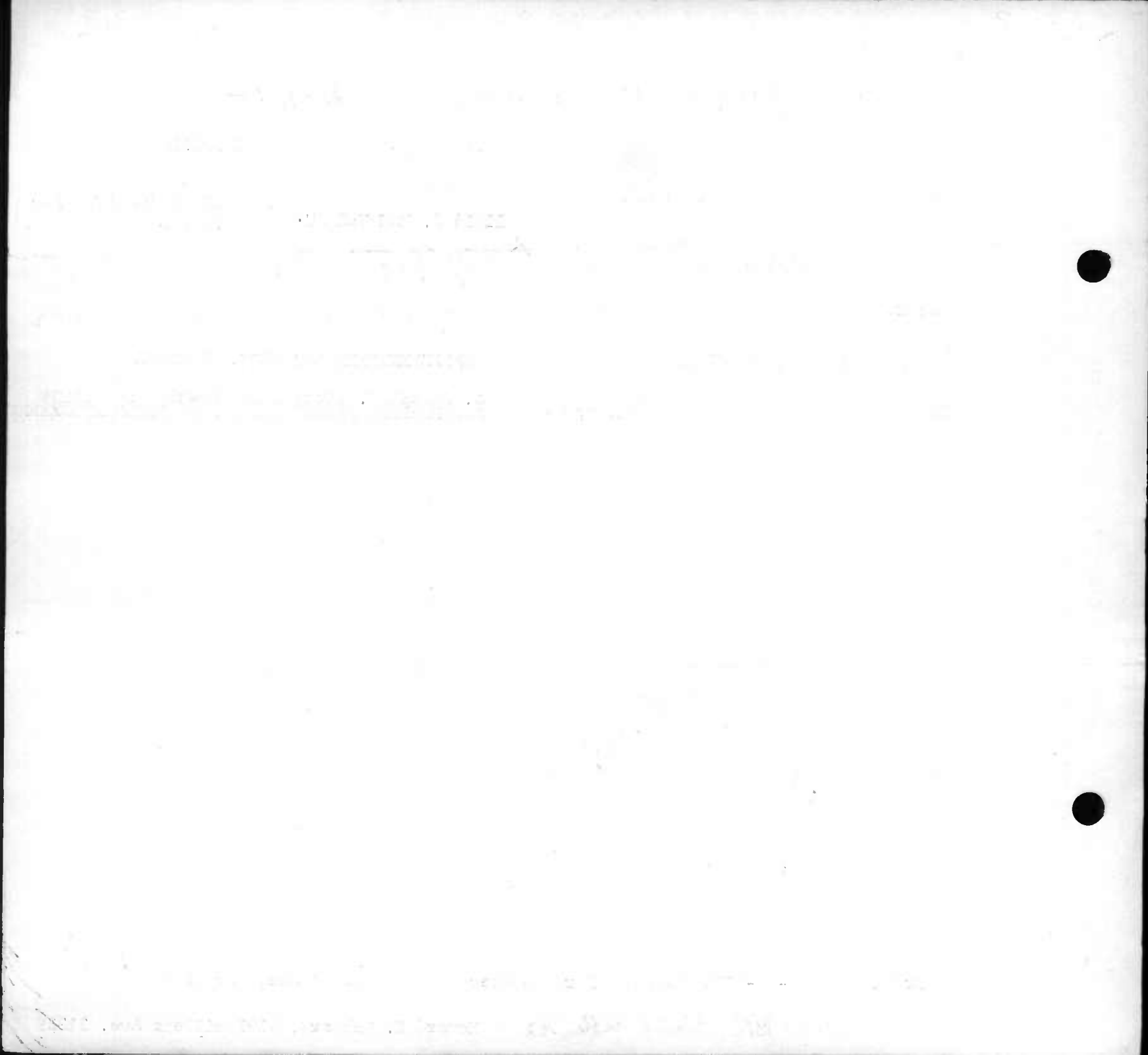
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-26-72		24C. NAME of CEMETERY or CREMATORY Green Haven		24D. LOCATION (City, town, or county) (State) Ritchie Hwy Glen Burnie Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR P. E. Farley, MD		25C. FUNERAL DIRECTOR Schweinsberg		25D. ADDRESS 1126 W. Cross St	

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1126 W. Cross St. 21230

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 06101		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06101	
1. NAME OF DECEASED (Type or Print) Miss Mary C. (Marie) Ritz			2. DATE AND HOUR OF DEATH 6/29/72 10:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2301 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1334 S. HANOVER ST. (XXXXXXXXXXXXXXXXXXXX)		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04/10/98	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Christian Ritz			14. MOTHER'S MAIDEN NAME KATHERINE RUSSELL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-12-6296		17. INFORMANT ADDRESS Mr. Joseph J. Ritz, 1639 Waverly Way 21239	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Septic Shock. DUE TO, OR AS A CONSEQUENCE OF: (B) Septicemia - DUE TO, OR AS A CONSEQUENCE OF: (C) Hypokalemia ASCVD.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/26/1972 to 6/27/1972 that (1) (we) last saw the deceased alive on 6/27/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ARVORANEE, M.D. DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ARVORANEE, M.D. DEGREE				23D. ADDRESS BON SECOURS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-1972		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		(State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06102	
72 06102				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		George H. Krapp		June 27, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
South Baltimore General			Maryland		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER					
1430 Patapsco St.					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 10, 1910	62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Multigraph Oper.			Maryland		
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Joseph Krapp			U.S.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			214 03 6028 Margaret Krapp, 1430 Patapsco St.,		
17. INFORMANT			ADDRESS		
			Baltimore, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Cormany Conclusion hours		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
II			Determined by Disease years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C)		
19A. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from April 1966 to June 1972, that (I) (we) last saw the deceased alive on 6/2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Walter Kohn			6/27/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Walter Kohn, M.D.			102 E. Fort Ave., Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/29/72		Holy Cross Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 30 1972		Robert E. Tabor, MD		George J. Gonco, 4001 Ritchie Hwy., Baltimore, Md. 21225	

June 11, 1975

June 11, 1975

Dear Mr. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Very truly yours,

[illegible]

[illegible]

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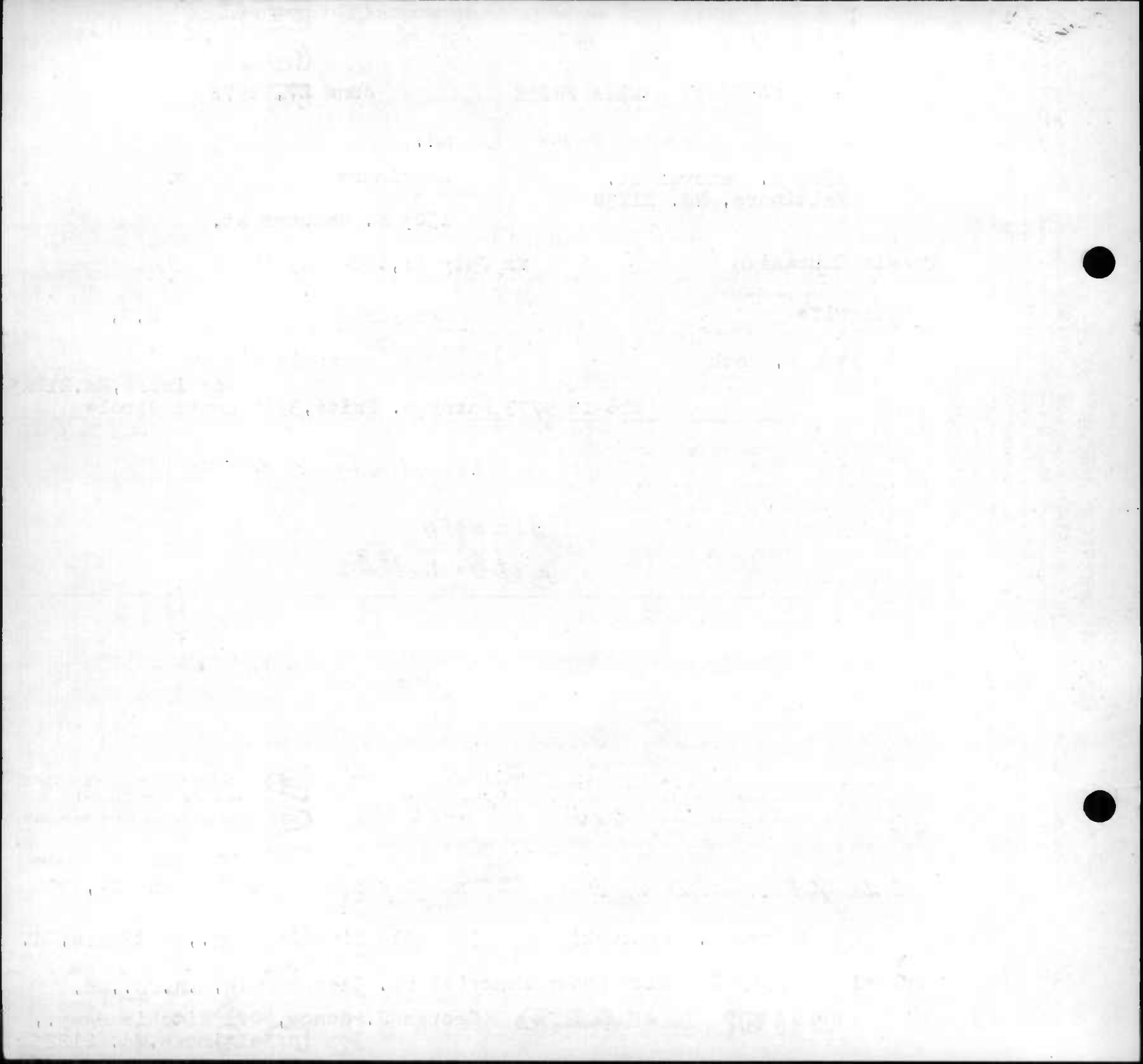
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06103	
BIRTH NO. 72 06103				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARGARET AMELIA FRITZ			2. DATE AND HOUR OF DEATH June 27, 1972 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2301		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1305 S. Hanover St. Baltimore, Md. 21230			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1305 S. Hanover St.		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 11, 1904 67		9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Peter H. Reth			14. MOTHER'S MAIDEN NAME Fannie Higdon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218 18 9773		17. INFORMANT ADDRESS Harry G. Fritz, 3919 Inner Circle Baltimore, Md. 21225
18. 250-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCULO Diphtheria mellitus			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 4 1970 to 6/8/72 19 72 that (I) (we) last saw the deceased alive on 6/8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Andrew R. Sosnowski M.D.				23B. DATE SIGNED June 27, 1972	
23C. PHYSICIAN'S NAME (Type) Andrew R. Sosnowski				23D. ADDRESS 30 4016 Ritchie Hgwy., Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/72		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Pk. Glen Burnie, A.A. Co., Md.	
24D. LOCATION Baltimore, Md. 21225		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Phyllis E. Fagan, R.D.	
25C. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hgwy., Baltimore, Md. 21225		25D. ADDRESS Baltimore, Md. 21225			

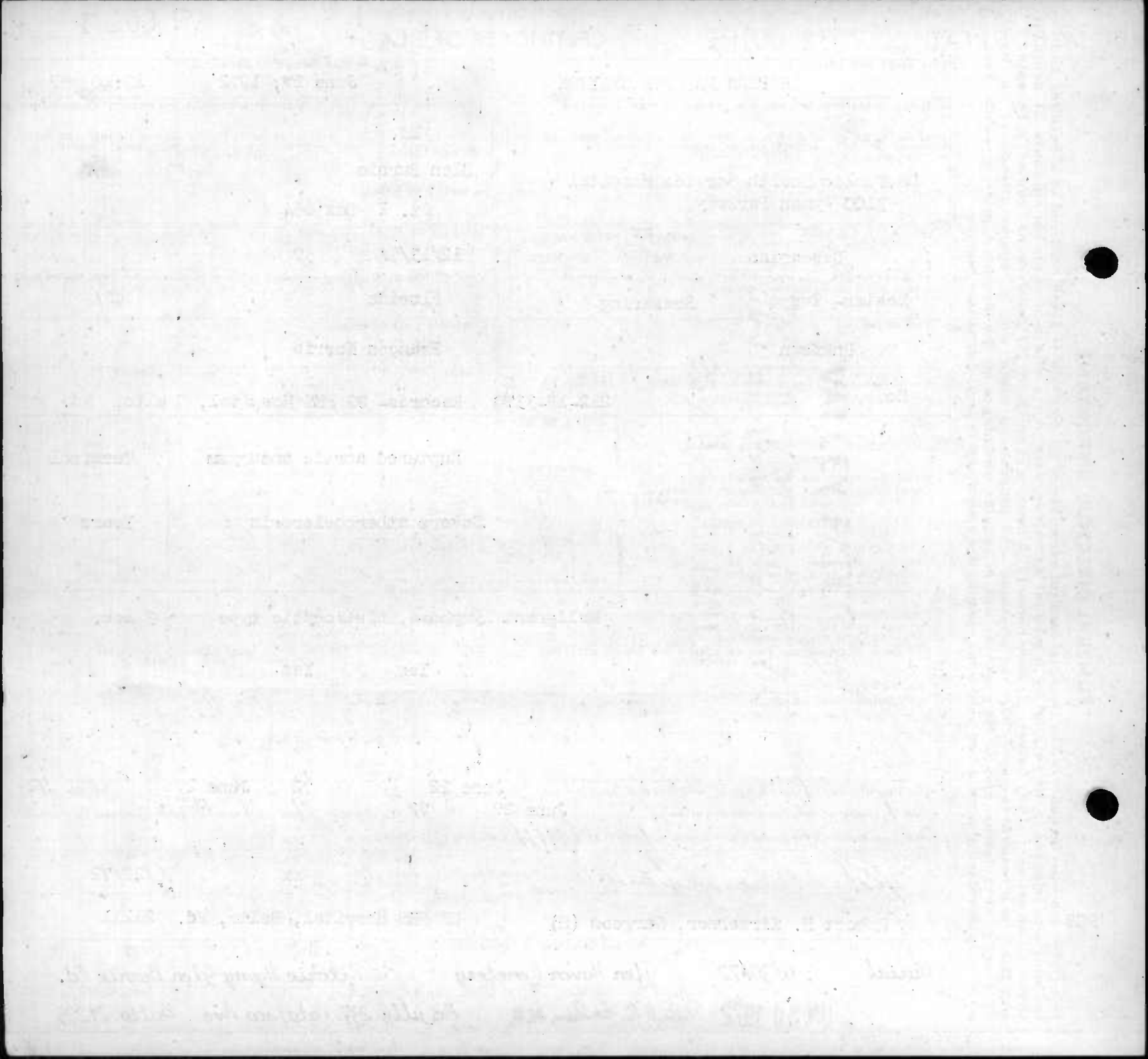


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06104	
BIRTH NO. 72 06104				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CHAPMAN MARLOWE CLAYTON			2. DATE AND HOUR OF DEATH June 27, 1972 10:40 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 5200 C. CITY OR TOWN Glen Burnie D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Rt. 2 Box 694		
5. SEX M	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/14	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master- tug		10B. KIND OF BUSINESS OR INDUSTRY Seafaring		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Frances Norris			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-18-3370			17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. 441-94-202-2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ruptured aortic aneurysm ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe atherosclerosis			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Terminal (B) DUE TO, OR AS A CONSEQUENCE OF: Years (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II			Malignant lymphoma, histiocytic type 3 mos.		
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 22 19 72 to June 27 19 72 , that (I) (we) last saw the deceased alive on June 27 19 72 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert H. Kirschner				23B. DATE SIGNED 6/28/72	
23C. PHYSICIAN'S NAME (Type) Robert H. Kirschner, Surgeon (R)				23D. ADDRESS US PHS Hospital, Balto, Md. 21211	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/72		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Hwy Glen Burnie Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972			
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS McCully 237 Patasco Ave Balto 21225			



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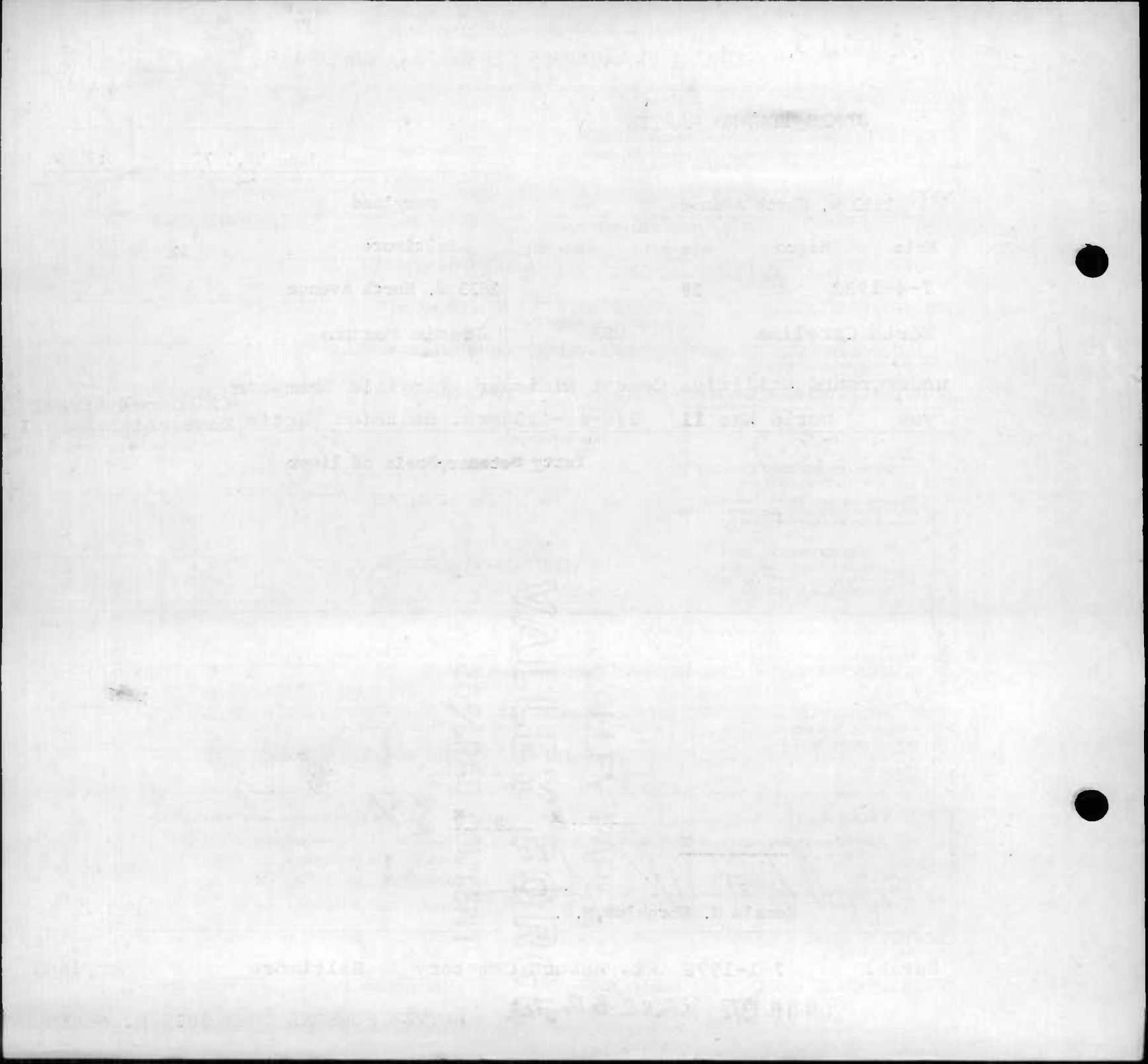
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06105

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES EDWARD MARTIN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2533 W. North Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour June 27, 1972 8:10 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1503		C. CITY OR TOWN Baltimore	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 7-4-1932		10. AGE (In years lost birthday) 39 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jessie Martin		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) underground Utilities Cement Finisher	
15. MOTHER'S MAIDEN NAME Virginia Thompson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II	
17. SOCIAL SECURITY NO. 246-46-6230		18. INFORMANT Mrs. Beatrice Martin	
19. CAUSE OF DEATH I 571.8 Fatty metamorphosis of liver (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH land	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/27/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-1972	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-6301

72 06106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 06106

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Benjamin Hardy

2. DATE AND HOUR OF DEATH

6-25-72

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2343 Edmondson Ave.

5. SEX

Male

6. RACE

Colored

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-1-86

9. AGE (In years last birthday)

86 85

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Waterfront

11. BIRTHPLACE (State or foreign country)

Maryland, Calvert Co.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lemuel Hardy

14. MOTHER'S MAIDEN NAME

Nelle Gross

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

705122106

17. INFORMANT

Marie Johnson

ADDRESS

2452 Woodbrook Ave

18. 412.2 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Hypertensive A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-6-65 to 6-16-1972 that (I) (we) last saw the deceased alive on 6-16-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C.R. Campbell, M.D.

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

6-27-72

23C. PHYSICIAN'S NAME (Type)

C.R. Campbell, M.D.

DEGREE

23D. ADDRESS

1618 West North Avenue, Baltimore, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

7-1-72

24C. NAME OF CEMETERY OR CREMATORY

Pium Point Chr. Cem.

24D. LOCATION

(City, town, or county)

Calvert Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

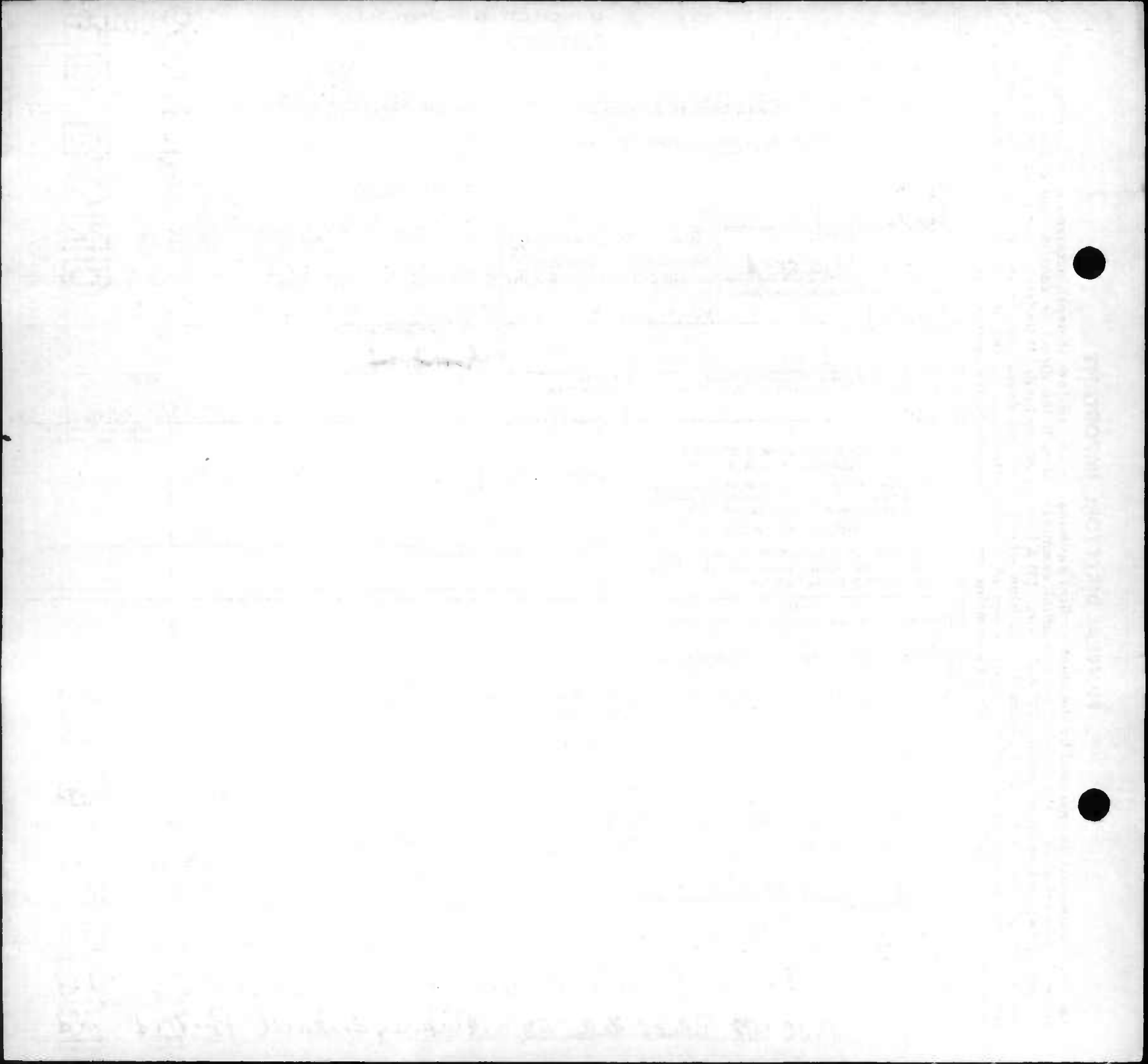
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

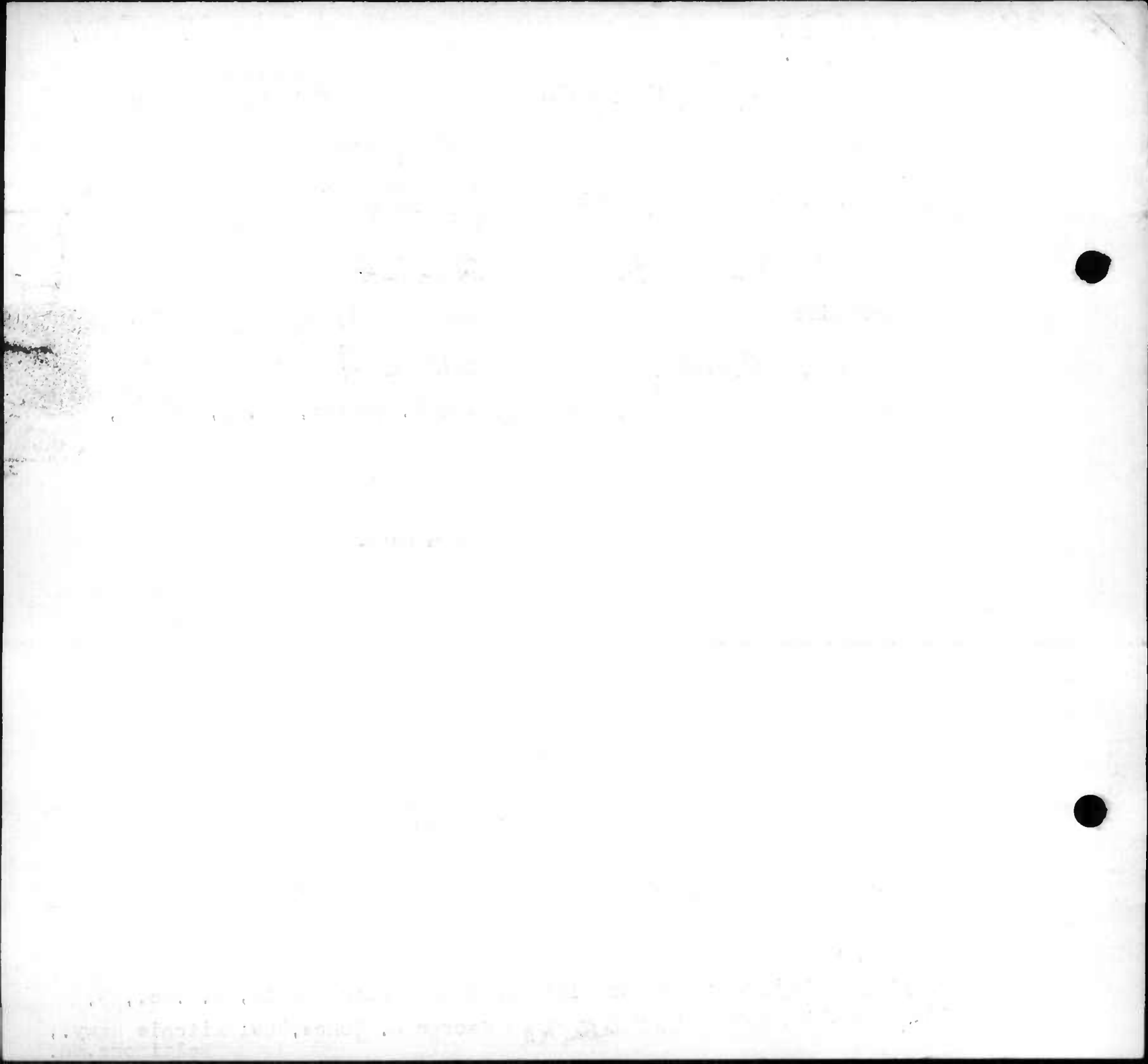
JUN 30 1972 R.B.E. Taber, Jr.

Pinkney A. Jewell Pr. Fred., md



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06107	
BIRTH NO. 72 06107		BIRTH NO. Ruby B. Piper	
1. NAME OF DECEASED (Type or Print) Mrs. Piper, Ruby B.		2. DATE AND HOUR OF DEATH 6-27-72 6.15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4 Bon Secours Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY AA C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Rt. 3 Box 83A	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/14
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 58
13. FATHER'S NAME John E. Crislip		14. MOTHER'S MAIDEN NAME Elsie A. Icecroft	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-22-3400	
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory failure		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.		17. INFORMANT Joe N. Vrabec, Rt. 3, Box 83A, Pasadena, Md.	
19. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)	
19A. DATE OF OPERATION		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-4-72 to 6-27-72 that (I) (we) last saw the deceased alive on 6-27-72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE VILAVAN THITIVARANA, M.D.		23B. DATE SIGNED 6-27-72	
23C. PHYSICIAN'S NAME (Type) Vilavan Thitivarana M.D.		23D. ADDRESS B.S.H.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 6/29/72	
24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, A.A.Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy., Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 06108</u>
BIRTH NO. <u>72 06108</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) THOMAS, ANITA MARGARET		2. DATE AND HOUR OF DEATH JUNE 28, 1972 2:40 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL 40		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2008 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 411 S AUGUSTA AVENUE 21229		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-16	9. AGE (In years last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Gustav Wirth		
14. MOTHER'S MAIDEN NAME Anna M. Renehan		15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		
18. 430.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rupture of aneurysm of posterior comm. artery (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pulmonary Congestion		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 26, 1972 to JUNE 28, 1972 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 28, 1972 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.				
23A. SIGNATURE Rahman Karimi		23B. DATE SIGNED 6/28/72		23C. PHYSICIAN'S NAME (Type) RAHMAN KARIMI, M.D.
23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7/1/72		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		24D. LOCATION (City, town, or county) (State) Elkridge, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Edw. S. MacNabb Sons, Inc. 301 Frederick Rd. Catonsville, Md.		

CERTIFICATE OF DEATH

JUNE 22, 1971

THOMAS, ALITA MARIE

MAITLAND

ST AGNES HOSPITAL

417 S AUGUSTA AVENUE

12-12-16

REMARKS: PNEUMONIA

MAITLAND

MAITLAND

CAUSE OF DEATH

CAUSE OF DEATH

ST AGNES HOSPITAL

NO

YES

JUNE 22, 1971

JUNE 22, 1971

JUNE 22, 1971

XX

BALTIMORE, MD

ST AGNES HOSPITAL

ST AGNES HOSPITAL

ST AGNES HOSPITAL

ST AGNES HOSPITAL

ST AGNES HOSPITAL

ST AGNES HOSPITAL

ST AGNES HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06108	
BIRTH NO. 72 06108				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) GRACE FOLDEPALER			2. DATE AND HOUR OF DEATH JUNE 27, 1972 720 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY S. HANOVER SR. 2301		
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F 6. RACE WHITE			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-27-23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home		9. AGE (In years last birthday) 49
11. BIRTHPLACE (State or foreign country) MD.			12. CITIZEN OF WHAT COUNTRY? MD.		
13. FATHER'S NAME JAS. BAILEY			14. MOTHER'S MAIDEN NAME BERTHA McMANUS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Family - Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CANCER OF BREAST			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. METASTASIS TO CHEST WALL, RIBS, AXILLA, LIVER, AND PROBABLY BRAIN					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 19 1972 to JUNE 27 1972 , that (I) (we) last saw the deceased alive on JUNE 19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nelson R. De Lara				23B. DATE SIGNED JUNE 27, 1972	
23C. PHYSICIAN'S NAME (Type) NELSON R. DE LARA				23D. ADDRESS SOUTH BALTIMORE GEN. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/1/72		24C. NAME of CEMETERY or CREMATORY Glen Haven	
24D. LOCATION Balt.		24E. CITY, town, or county Balt.		24F. STATE MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR R. E. J. J. J.		25C. FUNERAL DIRECTOR Mr. C. J. J. J.	
25D. ADDRESS 130 E. Fort St.					

CHANCE OF DEATH

RETURNED TO CHESTNUT ST.
JAN. 1, 1911
JAN. 1, 1911

CHANCE OF DEATH
JAN. 1, 1911



CHANCE OF DEATH
JAN. 1, 1911

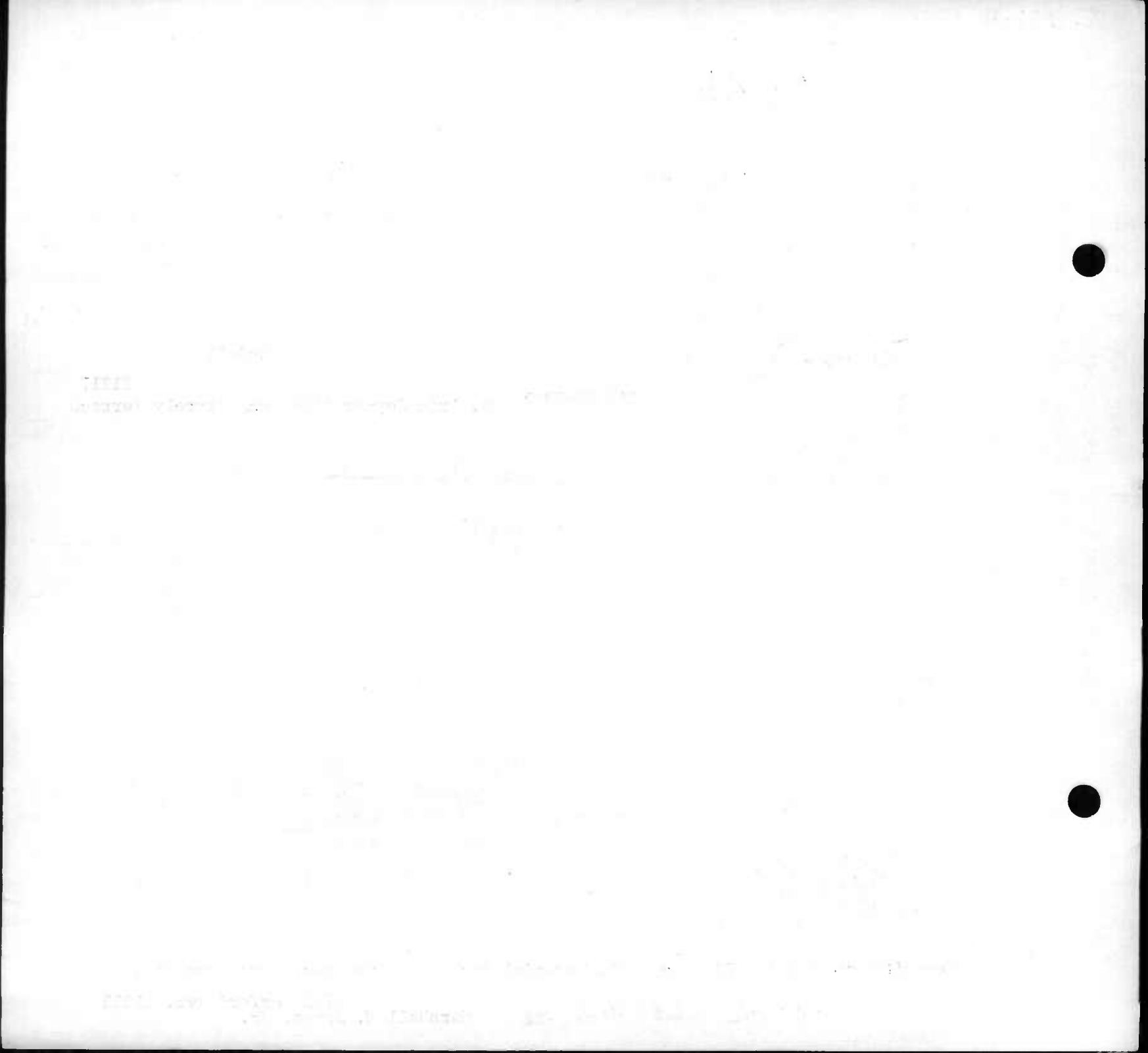
CHANCE OF DEATH
JAN. 1, 1911

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06110
BIRTH NO. 72 06110				
1. NAME OF DECEASED (Type or Print) LEWIS D. HOOD		2. DATE AND HOUR OF DEATH 6/26/72 3:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. Baltimore B. COUNTY C. CITY OR TOWN Ellicott City D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 10022 Fox Den Rd		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/97	9. AGE (In years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10B. KIND OF BUSINESS OR INDUSTRY Blue Ridge Fuel Co.		11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME JAMES R. HOOD		14. MOTHER'S MAIDEN NAME FRANCES E. DORSEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-16-2803		17. INFORMANT Mrs. Carol M. Hood
				ADDRESS Same
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Liposarcoma of left retroperitoneal space		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 weeks
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cerebral infarct, left parietal lobe 2 yrs				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 4-17-72 to 6-26-72, 1972, that (I) (we) last saw the deceased alive on 6-26-72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Vilvaran Thitharand, M.D.		23B. DATE SIGNED 6-26-72		23C. PHYSICIAN'S NAME (Type) VILVARAN THITHARAND, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6/27/72		24C. NAME OF CEMETERY OR CREMATORY J. Wm. Lee Sons, Inc.
24D. LOCATION Washington, D.C.		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		
25B. NAME OF REGISTRAR P. E. Jones		25C. FUNERAL DIRECTOR Edw. S. MacNabb Sons, Inc.		
25D. ADDRESS 301 Frederick Rd. Catonsville, Md.				

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 06111</u>	
BIRTH NO. <u>72 06111</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ELIZA M. JOYNER</u>		2. DATE AND HOUR OF DEATH <u>6/29/72 5:40 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIV. OF MARYLAND HOSP</u> <u>38</u>		A. STATE <u>MD.</u> B. COUNTY <u>1601</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALT.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>902 Bennett Place</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-20</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>N. C.</u>	9. AGE (In years last birthday) <u>51</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Joyner</u>		14. MOTHER'S MAIDEN NAME <u>Garnett Cogdell</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>242-18-8307</u>	
		17. INFORMANT <u>Mr. Eric Joyner 3444 Auchentoroly Terrace</u>	
		ADDRESS <u>21217</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>403 x 17-25014</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertension, Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/14</u> 19 <u>72</u> to <u>6/29</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6/29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Casper E. Cline III, M.D.</u>		23B. DATE SIGNED <u>6/29/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>CASPER E. CLINE III</u>		23D. ADDRESS <u>6607 COPPER RIDGE DR. BALT, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Transit-burial</u>		24B. DATE <u>7-3-1972</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Kinston, North Carolina</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>1735 Harford Ave. 21215 Marshall W. Jones, Jr.</u>			



C-6001

72 06112

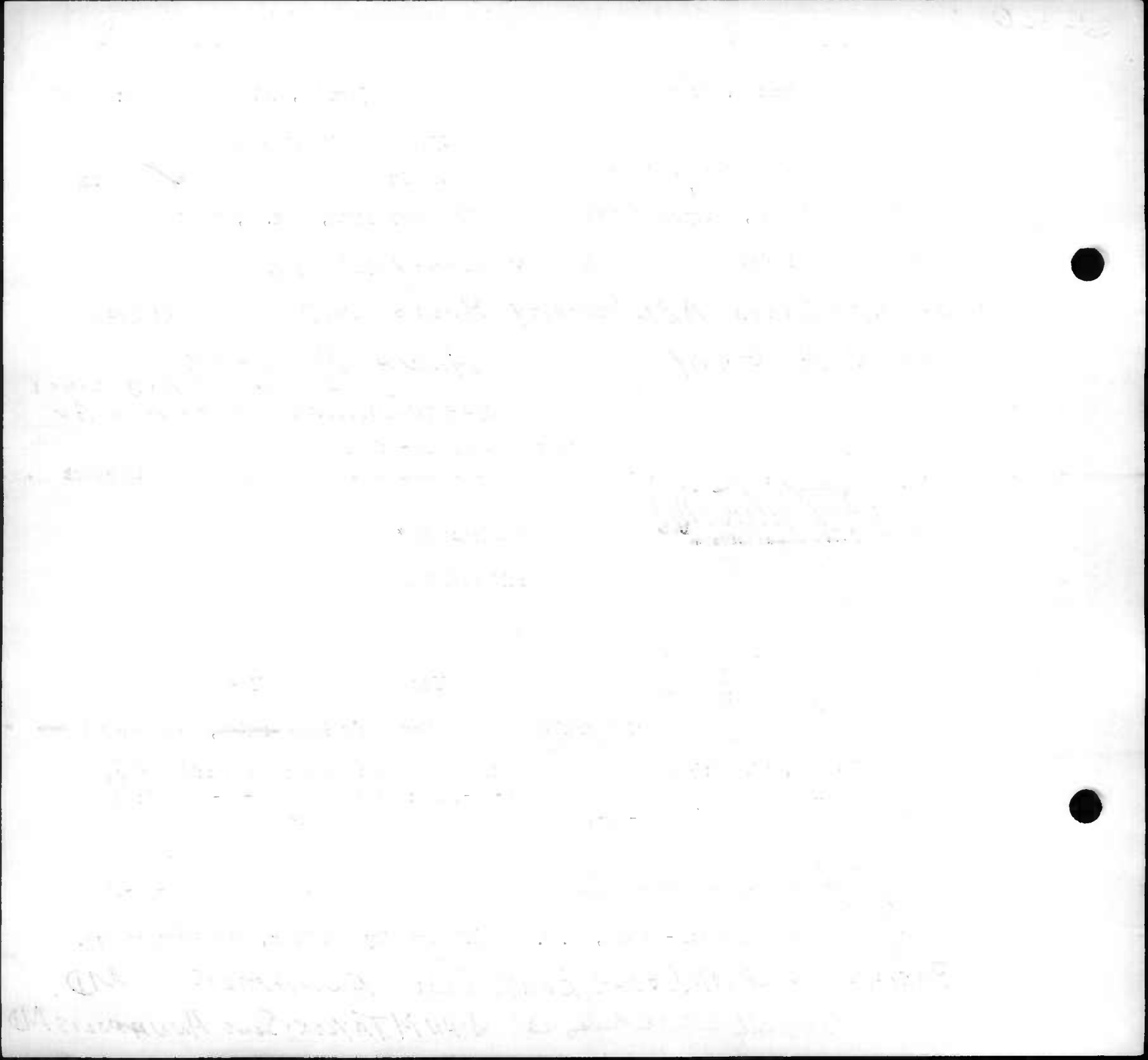
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 06112

BIRTH NO. 72 06112		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06112	
1. NAME OF DECEASED (Type or Print) Thomas W ^{LSO} Gray		2. DATE AND HOUR OF DEATH June 25, 1972 3:10 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland Anne Arundel 5210 C. CITY OR TOWN Annapolis D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 164 West Street, Apt. 2, 21401			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-4-1905	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECURITY GUARD		10B. KIND OF BUSINESS OR INDUSTRY A.B.C. SECURITY		11. BIRTHPLACE (State or foreign country) BALTO. MD	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN A GRAY		14. MOTHER'S MAIDEN NAME ANNA A CARR			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ANNAPOLIS MD 21401 MARION SULLIVAN 134 SPA View AV	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This space is for the physician's use only. e.g., heart failure, pneumonia, etc. If means the direct cause of death, state it.) E 887X1 CERTIFICATION APPROVED BY CHIEF OF MEDICAL STAFF DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Subdural hematoma - right (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Skull fracture * (B) DUE TO, OR AS A CONSEQUENCE OF: Accidental fall (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		None			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Gas station		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Barbour's Shell Station, 6435 Pulaski Hwy	
21D. TIME OF INJURY (APPROX.) June 25, 1972 5:30A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell back on his head accidentally	
22. I certify that (H) (this hospital) attended the deceased from 6-25-72 6:00AM 19 to 6-25-72 3:10PM 19 that (H) (we) last saw the deceased alive on 6-25-72 19 and that (H) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rafael Garcia-Bunuel M.D.		23B. DATE SIGNED 6-26-72		23C. PHYSICIAN'S NAME (Type) Rafael Garcia-Bunuel, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-28-1972		24C. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF CEM.	
24D. LOCATION ANNAPOLIS MD		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR JOHN M. TAYLOR		25D. ADDRESS ANNAPOLIS MD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 06113

BIRTH NO. 72 06113

1. NAME OF DECEASED

(Type or Print)

OSCAR HIERS

2. DATE AND HOUR OF DEATH

6/29/72 8:15

A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 The Johns Hopkins Hospital

4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

810 N. Port Street

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7/04/09

9. AGE (In years last birthday)

62

10. Under 1 Yr.

11. Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mechanics

10B. KIND OF BUSINESS OR INDUSTRY

Air Condition

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Philip Hiers

14. MOTHER'S MAIDEN NAME

Mamie Grines

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

YES

4/22/44 - 2/23/46

16. SOCIAL SECURITY NO.

217-07-4695

17. INFORMANT

ADDRESS

Johnnie Mae Hiers 810 N. Port St

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

METASTATIC ADENOCARCINOMA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE OF STOMACH
DUE TO, OR AS A CONSEQUENCE OF:

1 yr.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) CHRONIC RENAL FAILURE, MI

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 19 71 to 6/29 19 72
 that (I) (we) last saw the deceased alive on 6/29 19 72 and that in (my) (our) opinion death occurred on the date
 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John A. Nesbitt, III

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

6/29/72

23C. PHYSICIAN'S NAME (Type)

JOHN A. NESBITT, III

DEGREE

23D. ADDRESS

JOHNS HOPKINS HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/3/72

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION

(City, town, or county)

A. A. County, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 30 1972

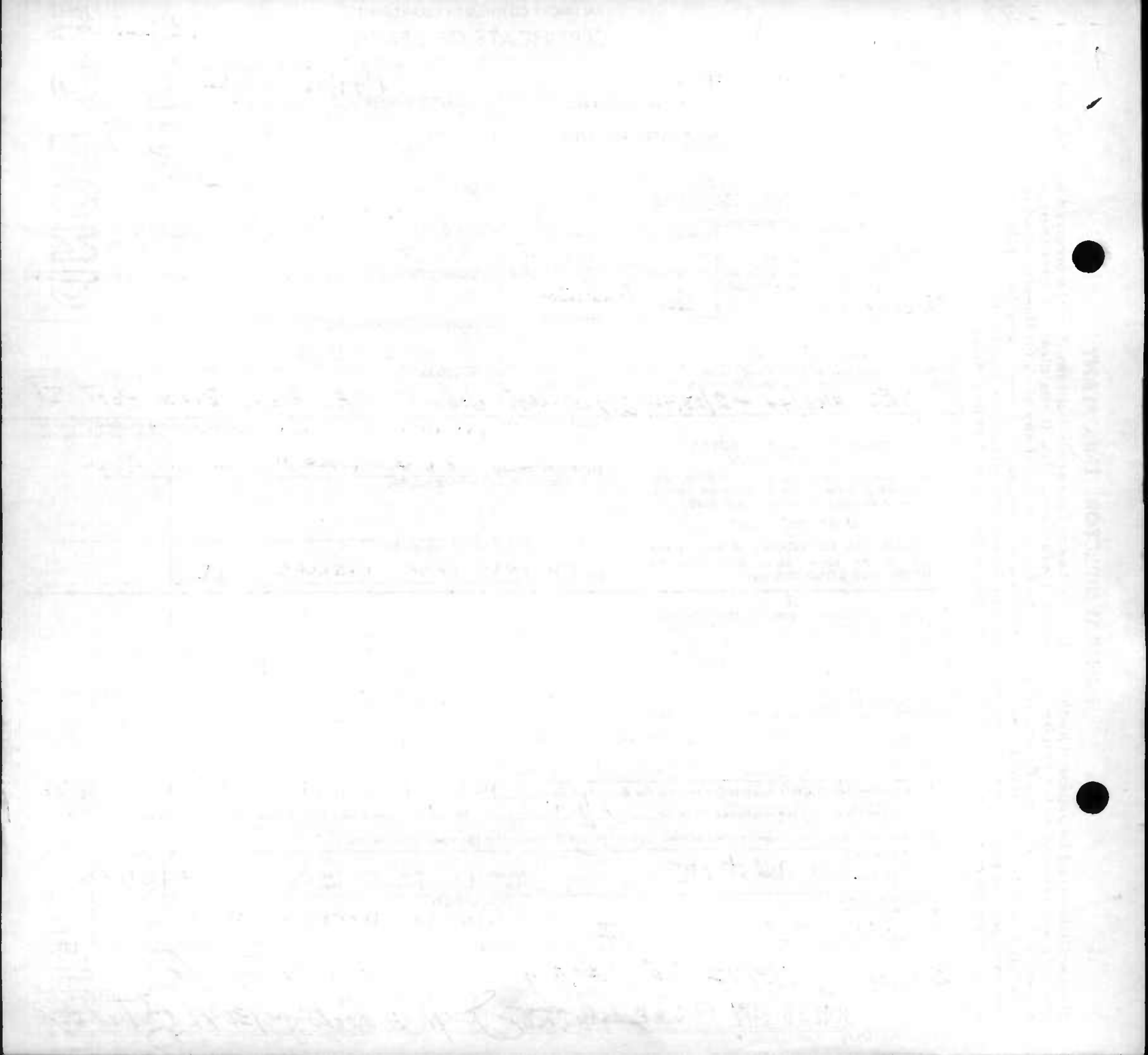
25B. NAME OF REGISTRAR

Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

Joseph B. Locks Jr. 13047. Central Ave

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

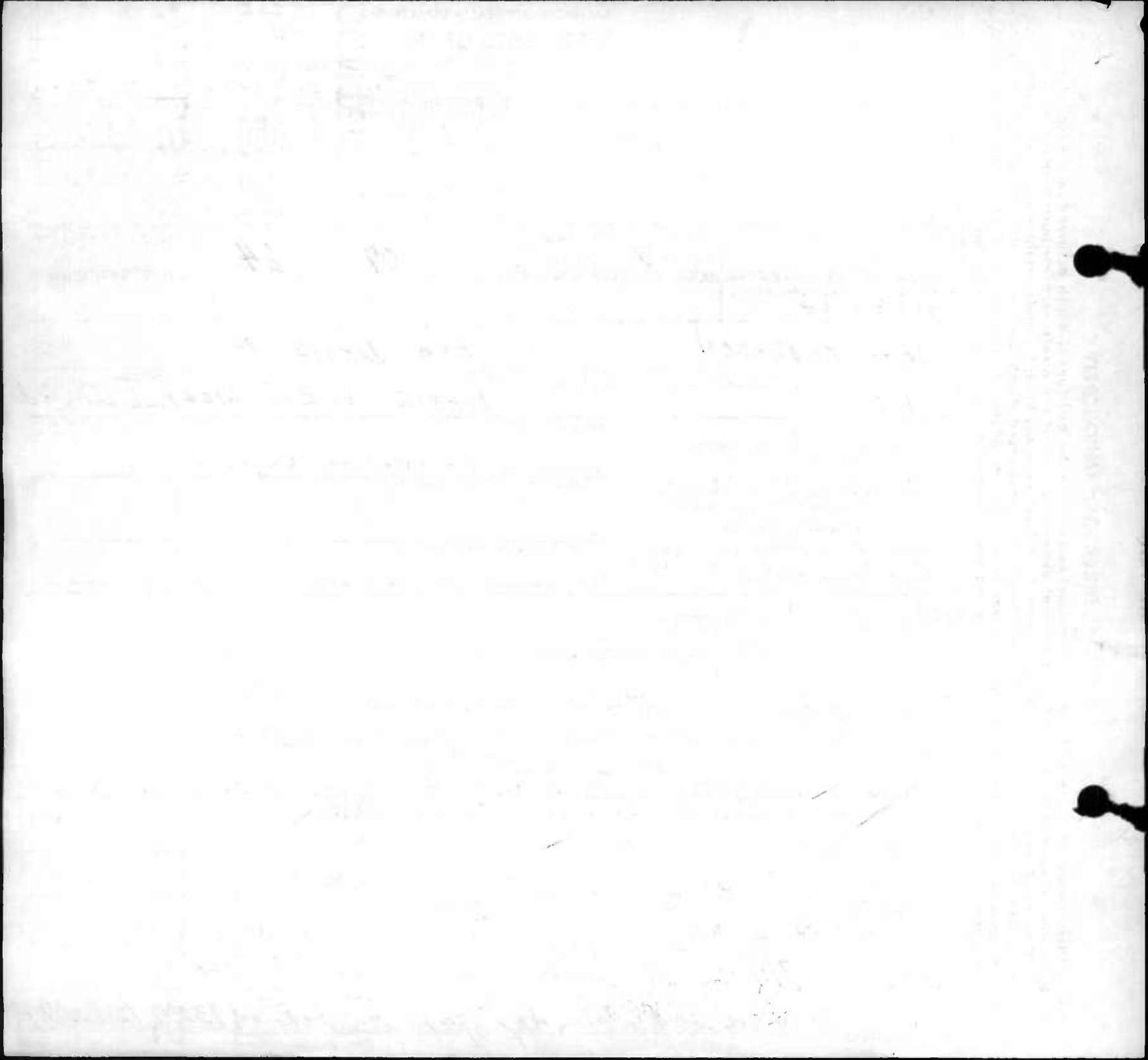
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 06114

BIRTH NO. 72 06114

1. NAME OF DECEASED (Type or Print) <u>Wongus, Mary</u>		2. DATE AND HOUR OF DEATH <u>JUNE 28, 1972</u> <u>5:55 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Provident Hospital</u> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1513</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4104 Reisterstown Rd.</u>	
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-07</u>
9. AGE (In years last birthday) <u>64</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>JEFF ANDERSON</u>		14. MOTHER'S MAIDEN NAME <u>EVA DAVIS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>MARIE WEST</u>		ADDRESS <u>4104 Reisterstown Rd</u>	
18. <u>269.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>MALNUTRITION, DEHYDRATION</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u></u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u></u>	
19A. DATE OF OPERATION <u></u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>	
20A. AUTOPSY? (Yes or No) <u></u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u></u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u></u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u></u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u></u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u></u>	
22. I certify that <u>W</u> (this hospital) attended the deceased from <u>May 15</u> 19 <u>72</u> to <u>June 28</u> 19 <u>72</u> that (I) <u>we</u> last saw the deceased alive on <u>June 28</u> 19 <u>72</u> and that (in <u>my</u>) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death.			
23A. SIGNATURE <u>Rayman, I. Ally</u>		23B. DATE SIGNED <u>6-28-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Rayman, I. Ally</u>		23D. ADDRESS <u>PROVIDENT HOSPITAL INC</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>	
25C. FUNERAL DIRECTOR <u>Joseph L. Locks</u>		ADDRESS <u>1304 N. Calhoun St</u>	



M-624

72 06115

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06115
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LENA MARSHALL		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> June 28, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1105 Wilmont Court		3. DATE PRONOUNCED DEAD Month Day Year Hour June 28, 1972 6:45 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1002			
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 7/15/50	10. AGE (In years lost birthday) 21	E. STREET AND NUMBER 1105 Wilmont Court	
11. BIRTHPLACE (State or foreign country) Balto. Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Rufus Marshall		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Rebecca Lloyd	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 219-52 8281	18. INFORMANT ADDRESS Rufus Marshall 1105 Wilmont Ct
19. CAUSE OF DEATH E966 I X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Stabwound of chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 28		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1105 Wilmont Court 1002			
22D. TIME OF INJURY (APPROX.) 6-28-72 about 5:00 P. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Stabbed during altercation			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 29, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/72	
24C. NAME OF CEMETERY or CREMATORY Not. Cemetery		24D. LOCATION (City, town, or county) (State) G. A. County, Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Joseph L. Locks		25D. ADDRESS 1304 N. Central St	

VALLEY PARK

VALLEY POLICE

7/1/50

7/1/50
DATE
PENDING
NO

Refuse removed
before 11:00

20-25

Summ 7/1/50 to 7/1/50
0-0 Cont. 20
7/1/50

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-240		72 06115		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06115	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANN ELIZABETH HAZEL		2. DATE AND HOUR OF DEATH JUNE 28 1972 5⁰⁵ A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals Baltimore Md. 4940 Eastern Avenue 21224				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 21202 1001			
5. SEX Female		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/16/1894	
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 4940 Eastern Avenue Baltimore, Maryland 21224 BCH: Records			
18. 4-3271 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CEREBROVASCULAR ACCIDENT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus; Syphilis				15 yrs.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 21 1972 to JUNE 28 1972 that (I) (we) last saw the deceased alive on JUNE 28 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard R. Love				23B. DATE SIGNED 6 28 72			
23C. PHYSICIAN'S NAME (Type) Richard R. Love, M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Jones		25C. FUNERAL DIRECTOR Adman, Penn		ADDRESS 1712 W. North Ave	

Handwritten text, mostly illegible due to fading and bleed-through. Visible fragments include:

Top left: 1000

Top center: 1000

Top right: 1000

Middle left: 1000

Middle center: 1000

Middle right: 1000

Bottom left: 1000

Bottom center: 1000

Bottom right: 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6531

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06117	
BIRTH NO. 72 06117				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		CARROLL BARNETT		2. DATE AND HOUR OF DEATH 6-28-72 12:50 P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2506		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
THE JOHNS HOPKINS HOSPITAL			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3312 FAIRFIELD RD.		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-02	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		Shoe Maker		York Co., S.C.	
13. FATHER'S NAME JASPER BARNETT			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO. 215-07-0889		17. INFORMANT Mrs. Hattie L. Barnett
			ADDRESS 3312 Fairfield Rd.		
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE CO CHEST DUE TO, OR AS A CONSEQUENCE OF: (B) METASTATIC CA OR STOMACH DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo 1 yr
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). none					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 19 72 to June 19 72 that (I) (we) last saw the deceased alive on June 28 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S D Nightingale M.D.			23B. DATE SIGNED 6/28/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
S. D. NIGHTINGALE M.D.			THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7/3/72		Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 30 1972		Robert E. Taylor, Jr.		Morton & Dyett F. H. 1701 Laurens St.	

UNITED STATES

70

1-22-03

BOARD

FRANKIE DUTTER

QUAKER GARRETT

THE JAMES O. LINDHART

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06118		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06118	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Young Joseph A.</i>		2. DATE AND HOUR OF DEATH <i>6/29/72 8:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>1601</i>		A. M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>46 LUTHERAN Hospital</i> <i>Baltimore, Md. 21216</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1135 N. CAREY ST</i>					
5. SEX <i>M</i>	6. RACE <i>B</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/13/11</i>	9. AGE (In years last birthday) <i>60</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND, BALTO</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>James Young</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Small</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-26-4784</i>		17. INFORMANT (Wife) <i>Hilda Young</i>	
ADDRESS <i>SAME</i>					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>SEPTICEMIA + SHOCK</i> (B) <i>cardiovascular accident - 4 sided</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Hemiplegia + in COMA.</i> (C) <i>old case of C.V.A. - (R) side Hemiplegia in 1971.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>6-29-72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/24/1972</i> to <i>6/29/1972</i> that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. San Dou</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/29/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. SAN DOU M.D.</i>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-3-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) (State) <i>Ba Ho, Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1972</i>		25B. NAME OF REGISTRAR <i>Robt E. Faber</i>		25C. FUNERAL DIRECTOR <i>Robert Dyett F.H.</i>	
ADDRESS <i>1701 - Lawrence St</i>					

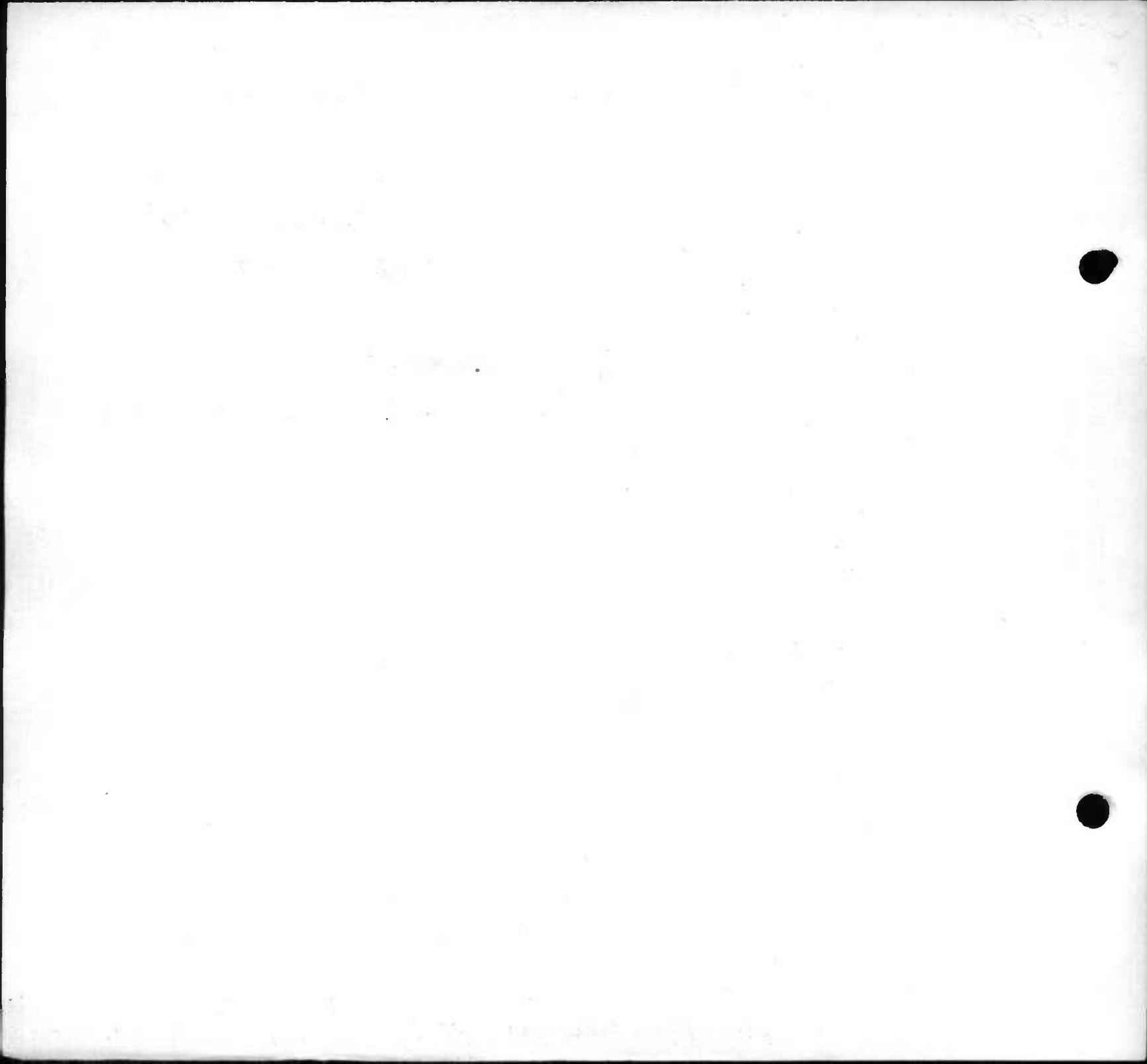
James M. Smith
March 1844

James M. Smith
March 1844

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06119	
BIRTH NO. 72 06119			
1. NAME OF DECEASED (Type or Print) Jones, Clara M.		2. DATE AND HOUR OF DEATH 4-26-72 7 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1403	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2309 Division, St	
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-13
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 59
13. FATHER'S NAME Edd Moyler		14. MOTHER'S MAIDEN NAME Patsy Spralley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-20-7513	
		17. INFORMANT ADDRESS Shephard Jones 2309 Division Street	
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF: of BREAST. (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 6-4-1972 to 6-26-1972 that (I) (we) last saw the deceased alive on 6-26-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. Sampat, M.D.		23B. DATE SIGNED 6-26-1972	
23C. PHYSICIAN'S NAME (Type) J-H. SAMPAT - M.D.		23D. ADDRESS LUTHERAN Hosp. of Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-72	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem.		24D. LOCATION (City, town, or county) (State) A.A., Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR Phillips Funeral Home		ADDRESS 1727 N. Monroe St	



FUNERAL DIRECTOR: IMPORTANT

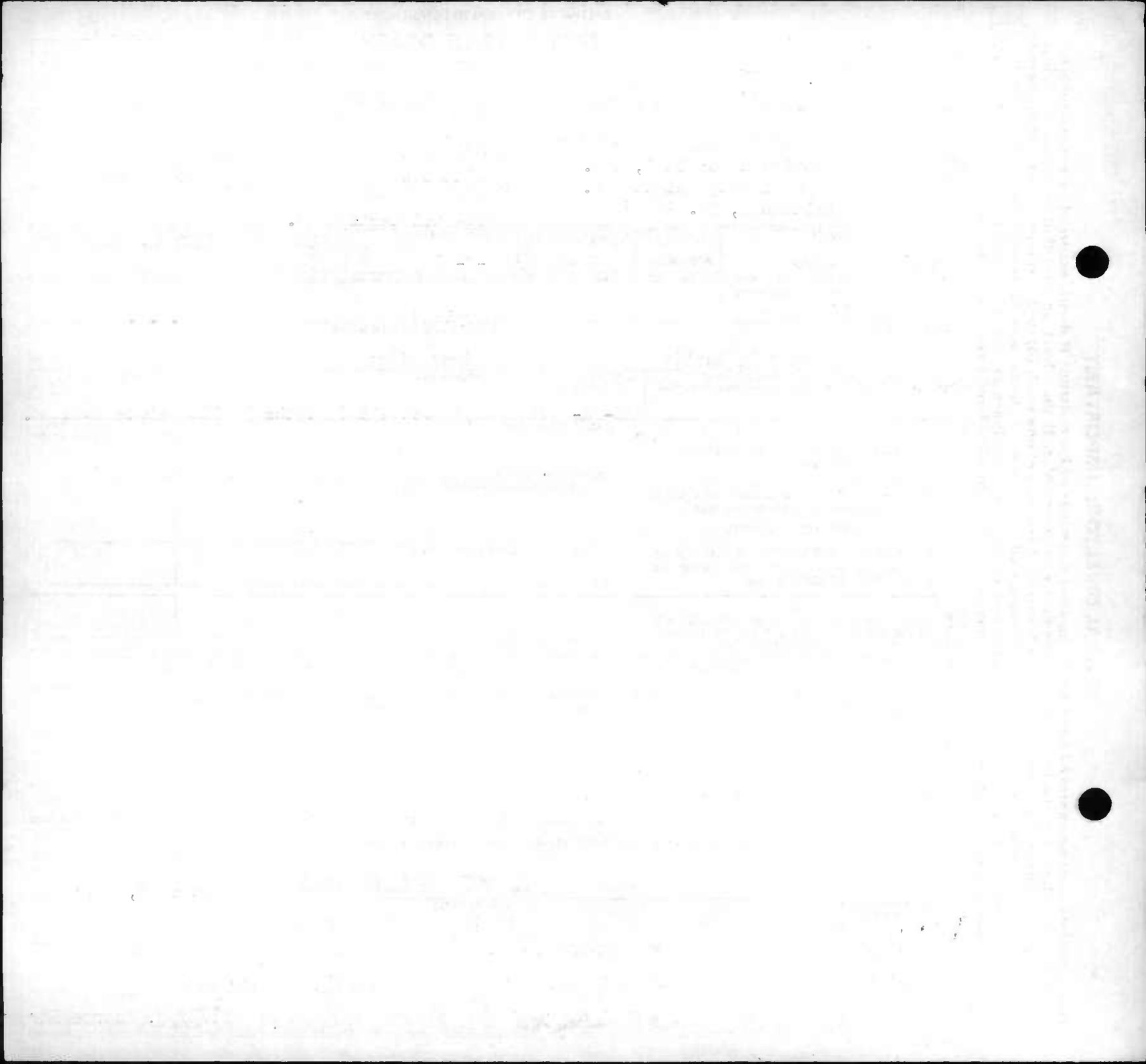
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-2351

BIRTH NO. 72 06120 CERTIFICATE OF DEATH

REG. NO. 72 06120

BIRTH NO. 72 06120		2. DATE AND HOUR OF DEATH JUNE 27, 72 9:25 AM	
1. NAME OF DECEASED (Type or Print) EDNA T. AUSTIN		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4324 Reistertown Rd.	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-2-17
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James L. Austin		14. MOTHER'S MAIDEN NAME Anna Diggs	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-10-9293	
17. INFORMANT Edna Cockrell (Daughter)		ADDRESS 4324 Reistertown Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ch. Renal failure 3 yrs (B) Ch. Pyelonephritis 3 yrs (C) Diabetes Mellitus 3 yrs	
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 18 19 72 to June 27 19 72 that (I) (we) last saw the deceased alive on June 27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Boon Varnasin		23B. DATE SIGNED June 27, 1972	
23C. PHYSICIAN'S NAME (Type) BOON VARNASIN		23D. ADDRESS Provident Hosp. Balto, Md 21215	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-72	
24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Phillips Funeral Home		ADDRESS 217 N. Monroe Street	



1
T-512

72 06121

BALTIMORE CITY HEALTH DEPARTMENT

72 06121

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HENRIETTA THOMPSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 25, 1972		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital (DQA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 25, 1972 2:15 A.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1603	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH March 26, 1940		10. AGE (In years lost birthday) 32 3/4	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 609 N. Mount Street
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Carter	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Pearl Wallace	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs. Pearl Janey 2508 W. Cold Spring Lane	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Two gunshot wounds of back (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 200 blk. Edmondson Avenue	
22D. TIME OF INJURY (APPROX.) 6-25-72 1:58 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. DATE SIGNED June 25, 1972					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-72		24C. NAME of CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland		24E. DATE REC'D BY HEALTH DEPT. JUN 30 1972			
25A. NAME OF REGISTRAR Robert E. Taylor, M.D.		25B. FUNERAL DIRECTOR Arlington S. Phillips		25C. ADDRESS 1727 N. Monroe Street	

22 C. 2000 Block Edmonson.

1
B-650

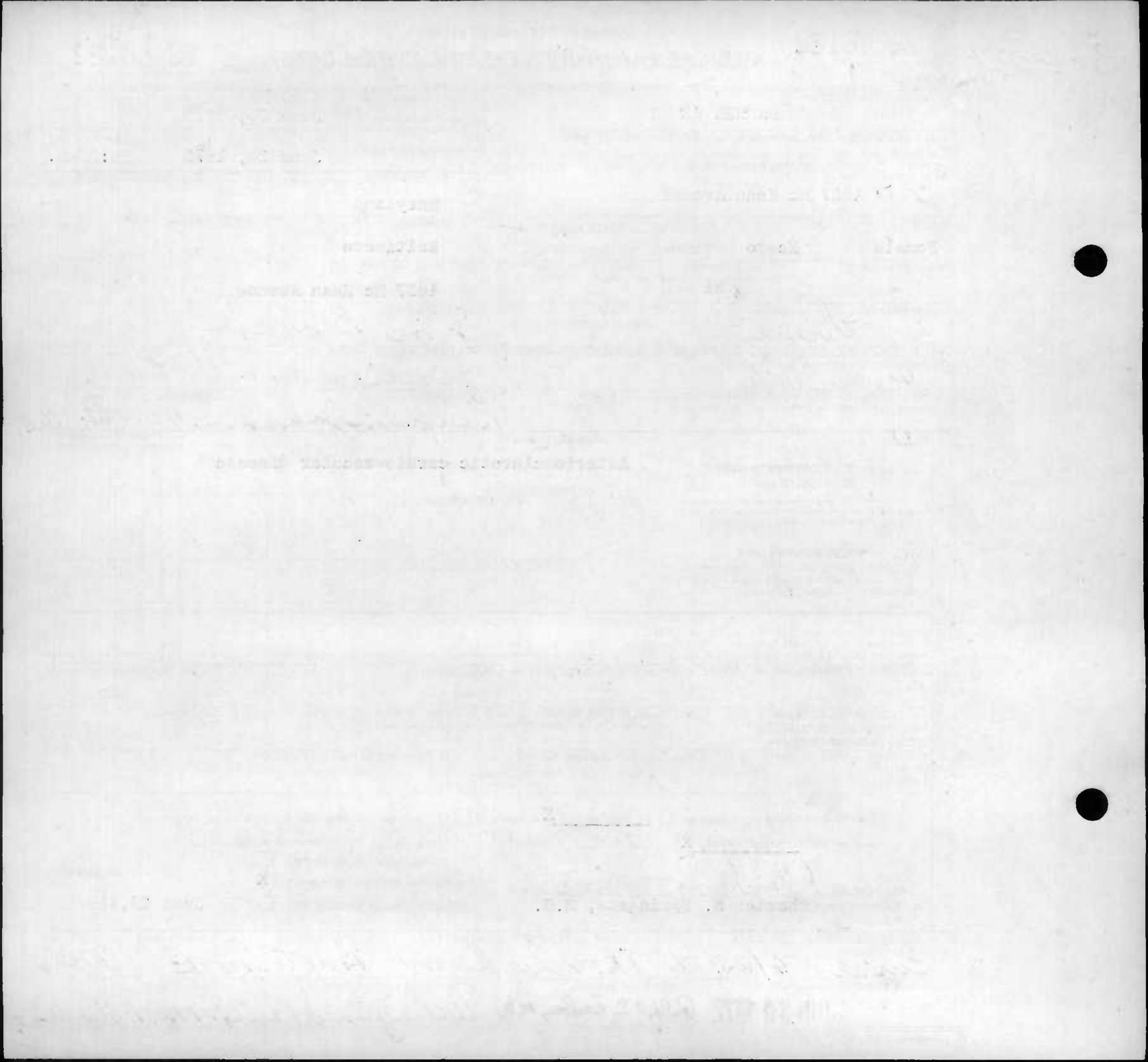
72 06122

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06122

BIRTH NO.		1. NAME OF DECEASED (Type or Print) NANNIE BROWN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour June 24, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1637 Mc Kean Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour June 24, 1972 11:35 A. M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1502	
6. SEX Female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH		10. AGE (In years last birthday) 81	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1637 Mc Kean Avenue
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Jim Brower	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Jennie M.N. Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Benjamin Johnson ADDRESS #570 Mt. George Ave.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 25, 1972					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/72	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Arlington & Phillips ADDRESS 1727 N. Meades St.	



R-200

72 06123

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06123

REG. NO.

BIRTH NO.

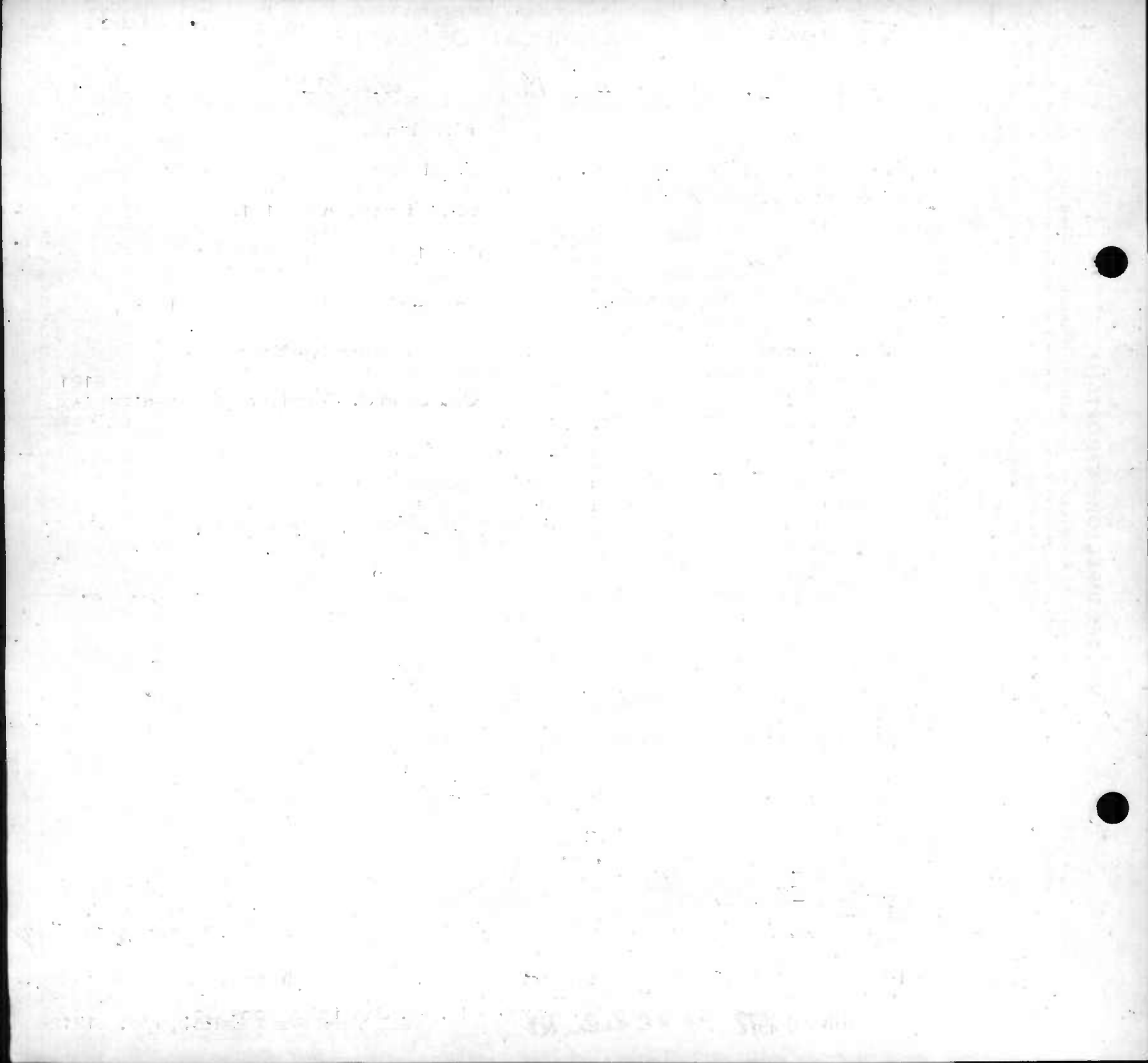
1. NAME OF DECEASED (Type or Print) WALTER ROUSE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year June 28, 1972 Hour 12:03 A.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH June 5, 1908		10. AGE (In years lost birthday) 64	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 248-14-0859	
18. INFORMANT Mr. & Mrs. Hubert Foxworth		ADDRESS 145 Siegwart Lane	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/28/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6-29-72	
24C. NAME of CEMETERY or CREMATORY Flaggpatch		24D. LOCATION (City, town, or county) (State) Flaggpatch, South Carolina	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe Street	

VALLEY FLOW
EQUILIBRIUM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

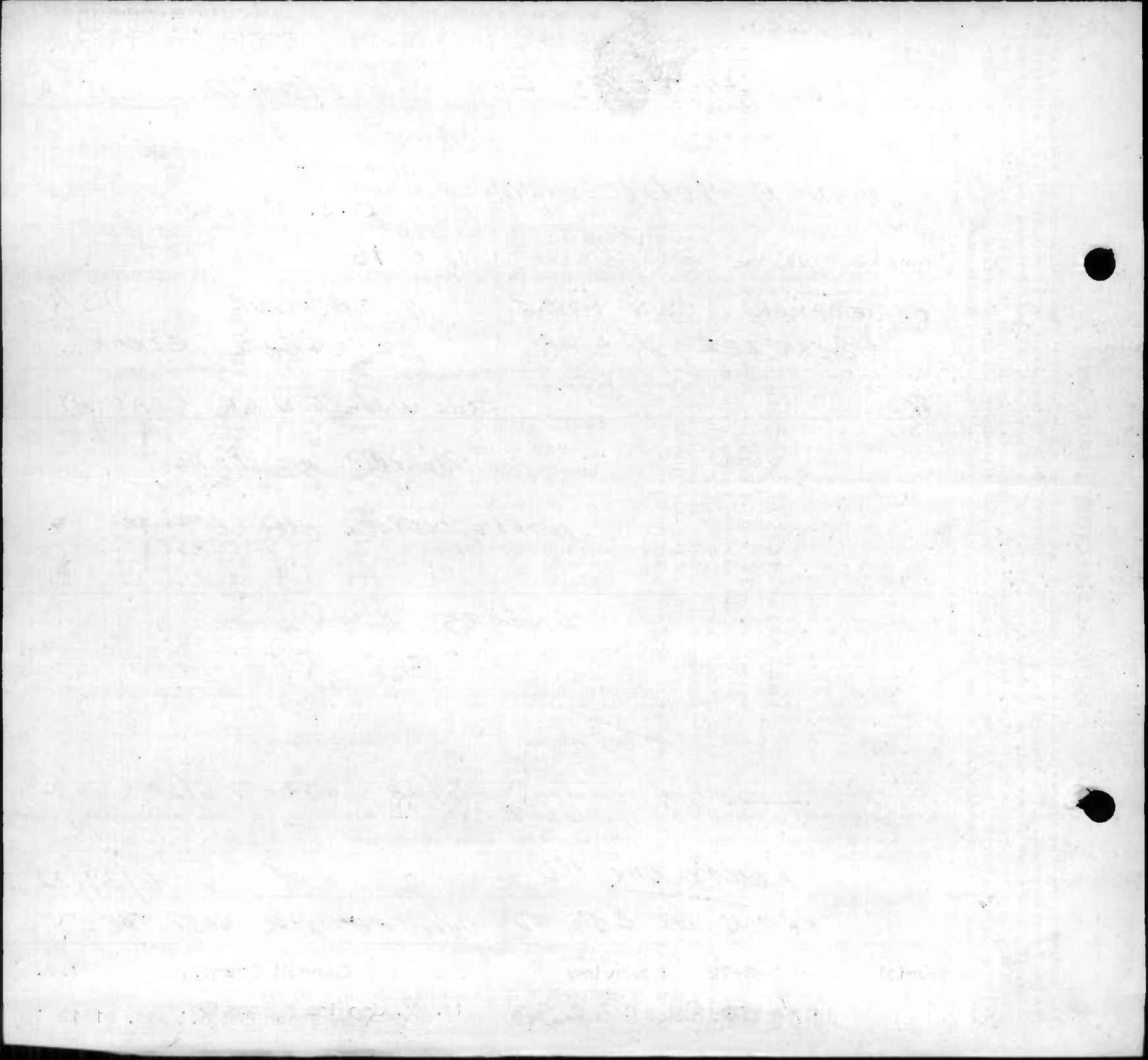
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06124	
72 06124				810 P.M.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Murray, Katherine M.</i>		2. DATE AND HOUR OF DEATH <i>6/29/72</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2710</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>900 Eaton Manor Nursing Home 3350 Wilkens Ave</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> * NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>506 Winston Ave 21212</i>	
5. SEX <i>Fe</i>	6. RACE <i>Can</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-6-1884</i>		9. AGE (In years last birthday) <i>87</i> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Ireland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>John Downes</i>	
14. MOTHER'S MAIDEN NAME <i>Anne Hastings</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Mr. John J. Carrigan 342 Rossiter Ave</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Myocardial Infarct.</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Chronic Heart Syndrome</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>6</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>5/22</i> 19 <i>72</i> to <i>6/29</i> 19 <i>72</i> , that (1) (we) last saw the deceased alive on <i>6/29</i> 19 <i>72</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>6/29/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>MIGUEL A. HEREDIA, M.D.</i>				23D. ADDRESS <i>3350 WILKENS AVE BALTO. MD 21244</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-3-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) <i>Baltimore,</i>		24E. (State) <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1972</i>		25B. NAME OF REGISTRAR <i>P. R. E. Feltz, MD</i>		25C. FUNERAL DIRECTOR <i>H. W. Jenkins & Sons Co.</i>	
ADDRESS <i>4905 York Road Balto., Md. 21212</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

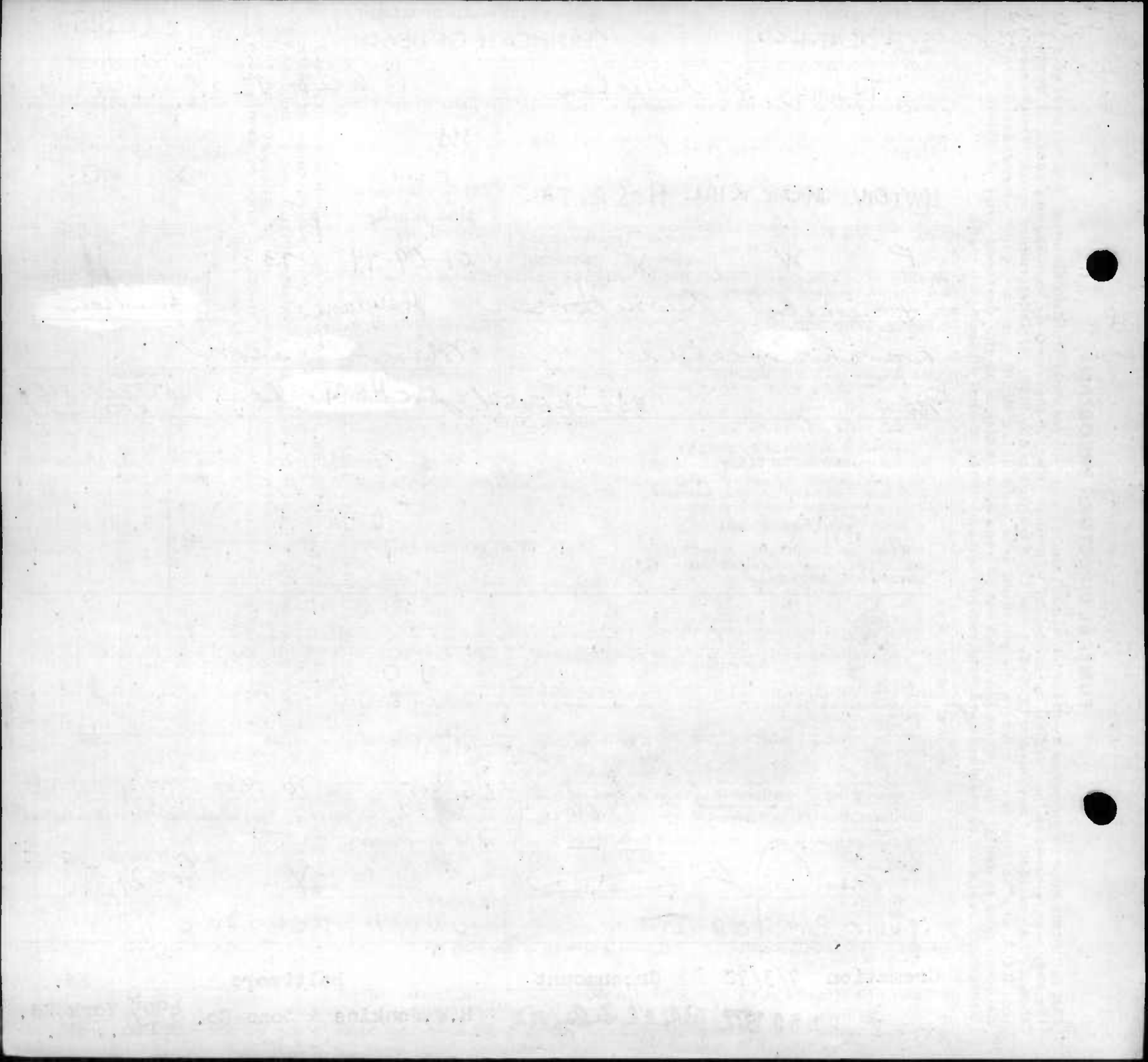
N-4251		72 06125		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06125	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) NELSON, Doris E.				2. DATE AND HOUR OF DEATH 6/29/72 7:25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2714			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Female		6. RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-01-16		9. AGE (In years last birthday) 55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) N. CAROLINA			12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME EBENEZER WILSON				14. MOTHER'S MAIDEN NAME ELIZABETH CLARK					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT JOHN W. NELSON, SR. (SAME)			
18. 410.91-250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PROBABLE MYOCARDIAL INFARCTION				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES, ANEMIA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/28 19 72 to 6/29 19 72 , that (I) (we) lost saw the deceased alive on 6/29 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ramon Del Busto MD						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/29/72	
23C. PHYSICIAN'S NAME (Type) RAMON DEL BUSTO MD						23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-72		24C. NAME OF CEMETERY or CREMATORY Lakeview		24D. LOCATION (City, town, or county) (State) Carroll County, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972				25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.			
						ADDRESS 4905 York Road Balto.; Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 06126</u>	
BIRTH NO. <u>72 06126</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Findings, Helen Harlan</u>			2. DATE AND HOUR OF DEATH <u>6-29-72</u> <u>1:15</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1202</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Marylander Apts</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01-09-99</u>	9. AGE (In years last birthday) <u>73</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Knock Harlan</u>			14. MOTHER'S MAIDEN NAME <u>Mary Benson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes or no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>359-28-5254</u>	17. INFORMANT <u>Joseph Harlan, 700</u>		ADDRESS <u>Little Blk 21202</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Severe MI. cardiac jct</u> DUE TO, OR AS A CONSEQUENCE OF: <u>stroke.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>4 days.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>06-25-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>06-25-72</u> to <u>06-29-72</u> , that (I) (we) last saw the deceased alive on <u>06-29-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>June 29, 72</u>		
23C. PHYSICIAN'S NAME (Type) <u>Julio Breyer, MD</u>			23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>7/3/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>	
ADDRESS <u>4905 York Rd. Balto., Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06127	
72 06127				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Angelina Rossini</i>		2. DATE AND HOUR OF DEATH <i>JUNE 28-1972 1:45 P. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>BALTO.</i>		C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Edgewood Nursing Home</i> <i>6000 Bellona Ave.</i> <i>Baltimore, Md. 21212</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>217 S. High St.</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/5/1917</i>	9. AGE (In years last birthday) <i>54</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>JOSEPH POMPEO</i>		14. MOTHER'S MAIDEN NAME <i>MARIA GRAZIA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MR. NICHOLAS ROSSINI 217 S. HIGH ST.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>4/2/25-250.9</i> CAUSE OF DEATH <i>Hypertensive Arteriosclerotic Cardio-Vascular Disease -</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis -</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Age - Similarity -</i> (C) <i>Diabetes mellitus -</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>several yrs.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5-24 1972</i> to <i>6-28 1972</i> , that (I) (we) last saw the deceased alive on <i>6-28 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Anthony F. Carozza</i>				23B. DATE SIGNED <i>6-28-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Anthony F. CAROZZA</i>				23D. ADDRESS <i>5217 York Rd Balto Md 21212</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7/1/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>GARDEN OF FAITH KENWOOD AVE. BALTO. Md.</i>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1972</i>		25B. NAME OF REGISTRAR <i>Robt E. Felt</i>	
25C. FUNERAL DIRECTOR <i>Norme M. Della-Vore</i>		25D. ADDRESS <i>322 S. HIGH ST.</i>			

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MARIA GRAZIA

JOSEPH POMPEO

MR. NICHOLAS ROSSINI 217 S. HIGH ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 06128	
BIRTH NO. 72 06128		1. NAME OF DECEASED (Type or Print) AUBREY W. ANDERSON SR.		2. DATE AND HOUR OF DEATH JUNE 26th./72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOS. IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 42				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTO. C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2798			
5. SEX M.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 4/07		9. AGE (in years last birthday) 65.	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GASOLINE ATT. SELF EMPLOYED GAS STATION			10B. KIND OF BUSINESS OR INDUSTRY RICHMOND VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME AUBREY ANDERSON.				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES. W.W.II.			16. SOCIAL SECURITY NO. 215-01-0814		17. INFORMANT MRS. ANTOINETTE ANDERSON. 5130 ARBUTUS AV		
18. 25-0-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF: (C) Treatment with		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 55 to 5 22 19 72 that (I) (we) last saw the deceased alive on 5/22 19 72 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Wilson				23B. DATE SIGNED 6/26/72			
23C. PHYSICIAN'S NAME (Type) WILFSON AND 5121 Park Heights				23D. ADDRESS 322 S. HIGH ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/30/72		24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER. BELAIR RD. AT MORAVIA AVE. BALTO. MD		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Wm. H. Kelly, Jr.			

5130 Arbutus Ave. 21215

Approved by Medical Examiner J. L. Griffin
 FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 06129		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06129	
1. NAME OF DECEASED (Type or Print) Myrtle Griffin		2. DATE AND HOUR OF DEATH June 26 1972 2 15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1547			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Mt Sinai Nursing Home 4612 Park Heights Ave Balto Md 21215		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None		8. DATE OF BIRTH 04-08-87	
13. FATHER'S NAME James Yerby		14. MOTHER'S MAIDEN NAME Mary Taylor		9. AGE (In years last birthday) 85	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-12-9969		11. BIRTHPLACE (State or foreign country) Virginia	
17. INFORMANT Mary G. Smith		ADDRESS 2316 Rosedale Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if rise to the above cause (A) standing UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION GIVEN IN PART 18.		(B) DUE TO, OR AS A CONSEQUENCE OF: Fracture of Left Hip			
19A. DATE OF OPERATION April 23 - 1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2316 Rosedale St.	
21D. TIME OF INJURY (APPROX.) April 23 - 1972		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fall at Home	
22. I certify that (I) (this hospital) attended the deceased from June 24 1972 to June 26 1972 that (I) (we) last saw the deceased alive on June 26 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis T. Lavvy M.D.		23B. DATE SIGNED June 26-1972		23C. PHYSICIAN'S NAME (Type) LOUIS T. LAVVY	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-72		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1972		25B. NAME OF REGISTRAR Robert E. Tabor, Md.		25C. FUNERAL DIRECTOR Kenneth Law	
24D. LOCATION Arbutus, Maryland		ADDRESS 4611 Park Heights Ave.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				STATE OF MARYLAND - DEPT.		REG. NO. 72 06130	
CERTIFICATE OF DEATH							
BIRTH NO. 72 06130				1. NAME OF DECEASED (Type or Print) CREEGER, ELEANORA MAUDE			
2. DATE AND HOUR OF DEATH JUNE 29, 1972 6:20A, M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 21228			
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 25F MONTROSE MANOR APTS. - Catonsville							
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02 21 02	9. AGE (In years last birthday) 70	10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Clerk Balto. Transit Co.				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN ANDREW STERNER			
14. MOTHER'S MAIDEN NAME IDA MAY (CRAUMER)				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 217183069				17. INFORMANT WILKENS AVES. BALTO., MD. 21229 RECORDS OF ST. AGNES HOSPITAL - CATON &			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sepsisemic Shock (B) DUE TO, OR AS A CONSEQUENCE OF: Rupture of Colon Polyps (C) DUE TO, OR AS A CONSEQUENCE OF: Rectal Polyps			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 6.6.1972				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Colonic Polyps			
20A. AUTOPSY? (Yes or No) NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from JUNE 5 19 72 to JUNE 29 1972, that (X) (we) last saw the deceased alive on JUNE 29 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) did (XXXX) view the body after death.							
23A. SIGNATURE Bilal Qureshi				23B. DATE SIGNED June 29 72			
23C. PHYSICIAN'S NAME (Type) DR. BILAL A. QURESHI				23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment				24B. DATE 7/1/72			
24C. NAME OF CEMETERY OR CREMATORY Lorraine Park-Mausoleum				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972				25B. NAME OF REGISTRAR Sydney W. Weston			
25C. FUNERAL DIRECTOR 736 Edmondson Ave. Catonsville, Md. 21228							

DATE OF DEATH

DATE OF BIRTH

ST. ANNE'S HOSPITAL

ST. ANNE'S HOSPITAL

ST. ANNE'S HOSPITAL

ST. ANNE'S HOSPITAL

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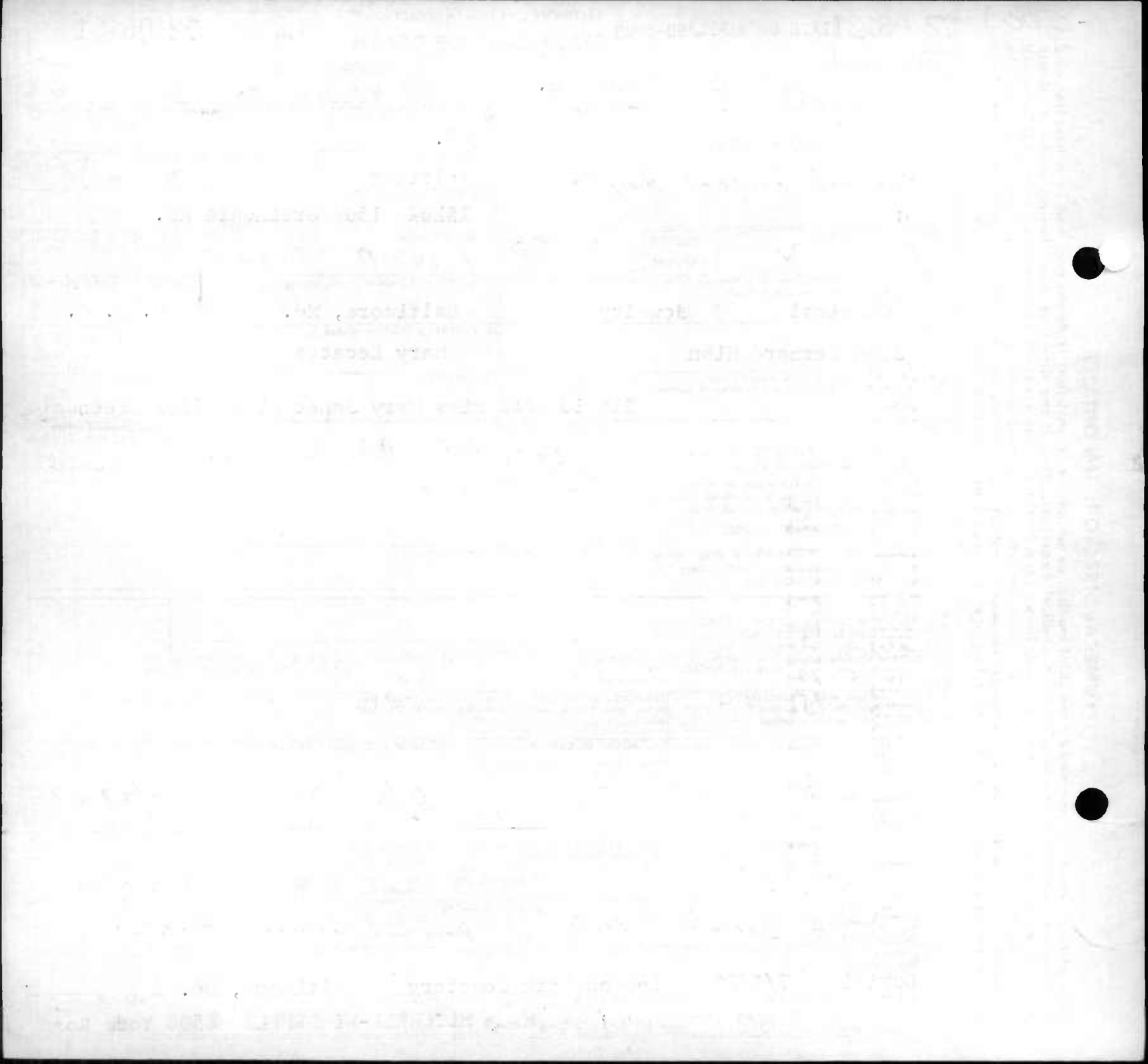
ST. ANNE'S HOSPITAL

ST. ANNE'S HOSPITAL

ST. ANNE'S HOSPITAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06131		STATE OF MARYLAND - DEPARTMENT OF HEALTH		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06131	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HIHN, Edna M.				2. DATE AND HOUR OF DEATH 27 June 72 3:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 902			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1509 Greendale Rd.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-24-91	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10B. KIND OF BUSINESS OR INDUSTRY Jewelry		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Bernard Hihn				14. MOTHER'S MAIDEN NAME Mary Lecates			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 10 8666		17. INFORMANT ADDRESS Miss Mary Janet Hihn 1509 Greendale			
18. 199.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Metastatic Adeno Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH Metastatic Adeno Carcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION 16-15-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tamndice		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/6 19 72 to 6/27 19 72 that (I) (we) last saw the deceased alive on 6/27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. H. Ziegler M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/27/72	
23C. PHYSICIAN'S NAME (Type) J. H. Ziegler, M.D.				23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/72		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Sidney W. Weston		25C. FUNERAL DIRECTOR MITCHELL WIEDEFELD		ADDRESS 6500 York Road	



P. 624

STATE OF MARYLAND - DEPT. BALTIMORE CITY HEALTH DEPARTMENT

72 06132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 06132

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAY GREER PARKER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> June 28, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 rear of 311 S. Sharp Street (Parking lot)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1972 1:05 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Richmond	
9. DATE OF BIRTH OCT 8 1928		10. AGE (In years last birthday) 43	
11. BIRTHPLACE (State or foreign country) Hertford Co. N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind at work done during most of working life, even if retired) Laborer.		14B. KIND OF BUSINESS OR INDUSTRY Box Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME SARA GREENE.		18. INFORMANT Helen Parker.	
19. E 820.17		ADDRESS A Hoskie N.C.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Parking lot 5	
22D. TIME OF INJURY (APPROX.) 6-28-72 about 11:30 P.m.		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) rear of 311 S. Sharp Street 2201	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Apparently passed out under a truck that presumably accidentally ran over subject	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) Yes	
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 1 1972	
24C. NAME OF CEMETERY OR CREMATORY AULANDER CEMETERY		24D. LOCATION (City, town, or county) (State) AULANDER N.C.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR GARRETT FUNERAL HOME		ADDRESS A HOSKIE N.C.	

VS 151-REV. 1/1/68

N 996.87

Oct 9 1938
 Mr. J. C. McCall
 Laborer
 Box Co.
 Mrs. W. W. E.
 Helen Parker
 Sarah Greene
 Joseph P. Parker

BUREAU
 TOTAL 1938
 ALEXANDER CAMPBELL
 ALEXANDER M. C.
 GARRETT FINEARTS FINE ARTS & INK

1
F-432

72 06133

STATE OF MARYLAND-DEHE

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06133

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LILLIAN FIELDS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 808 N. Chapel Street		3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1972 6:35 A.M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 704	
6. SEX Female	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9/22/89		10. AGE (In years last birthday) 82	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 808 N. Chapel Street
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? -		13. FATHER'S NAME William Aloas	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		14B. KIND OF BUSINESS OR INDUSTRY at home		15. MOTHER'S MAIDEN NAME -	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. -		18. INFORMANT ADDRESS John Fields & son) same as above	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 29, 1972 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/1/72		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Andrew H. Hooton		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	

RECEIVED

1964

1964

MAIL ROOM

1964

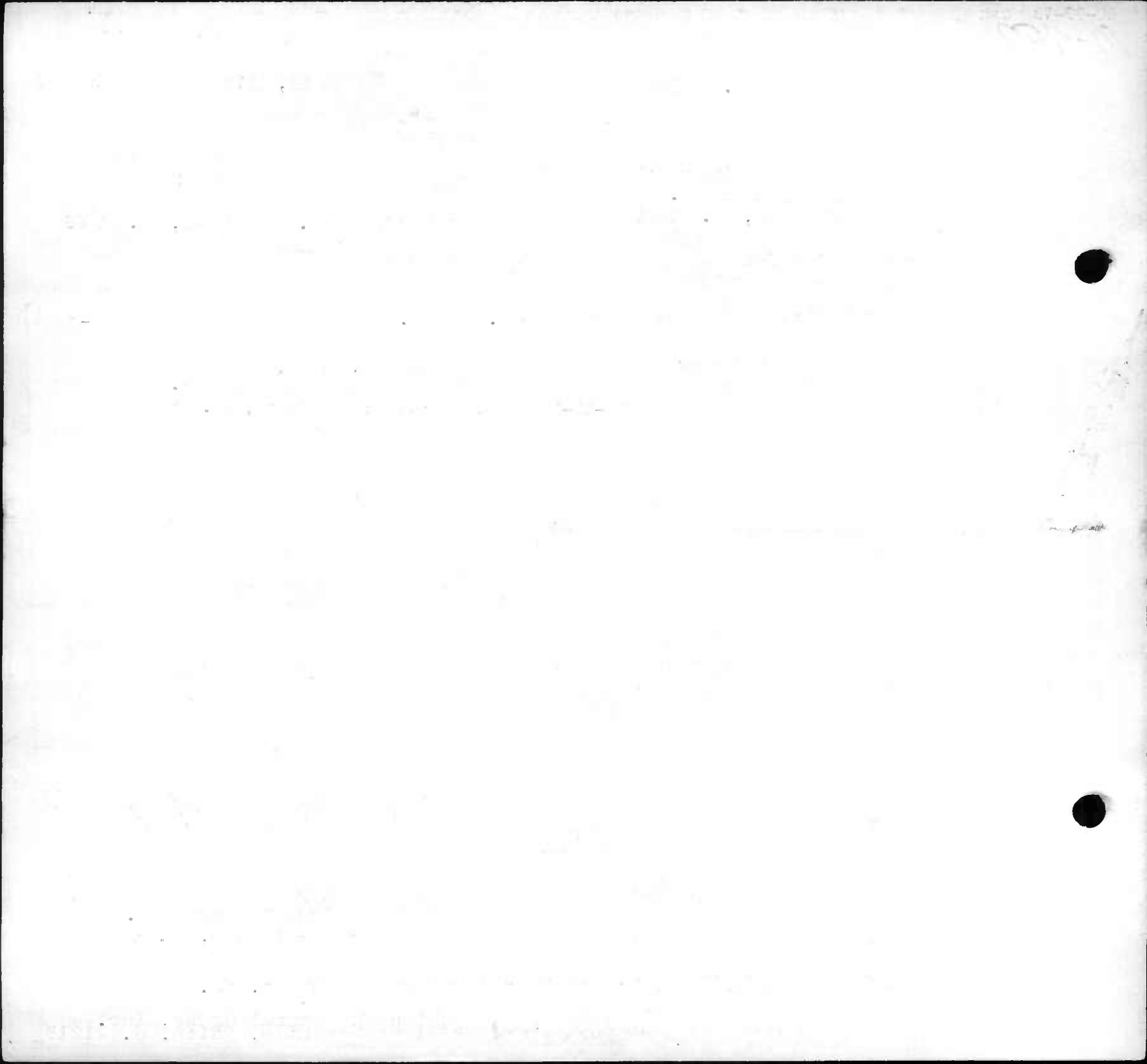
1964

60-99-73 csk
M-450

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

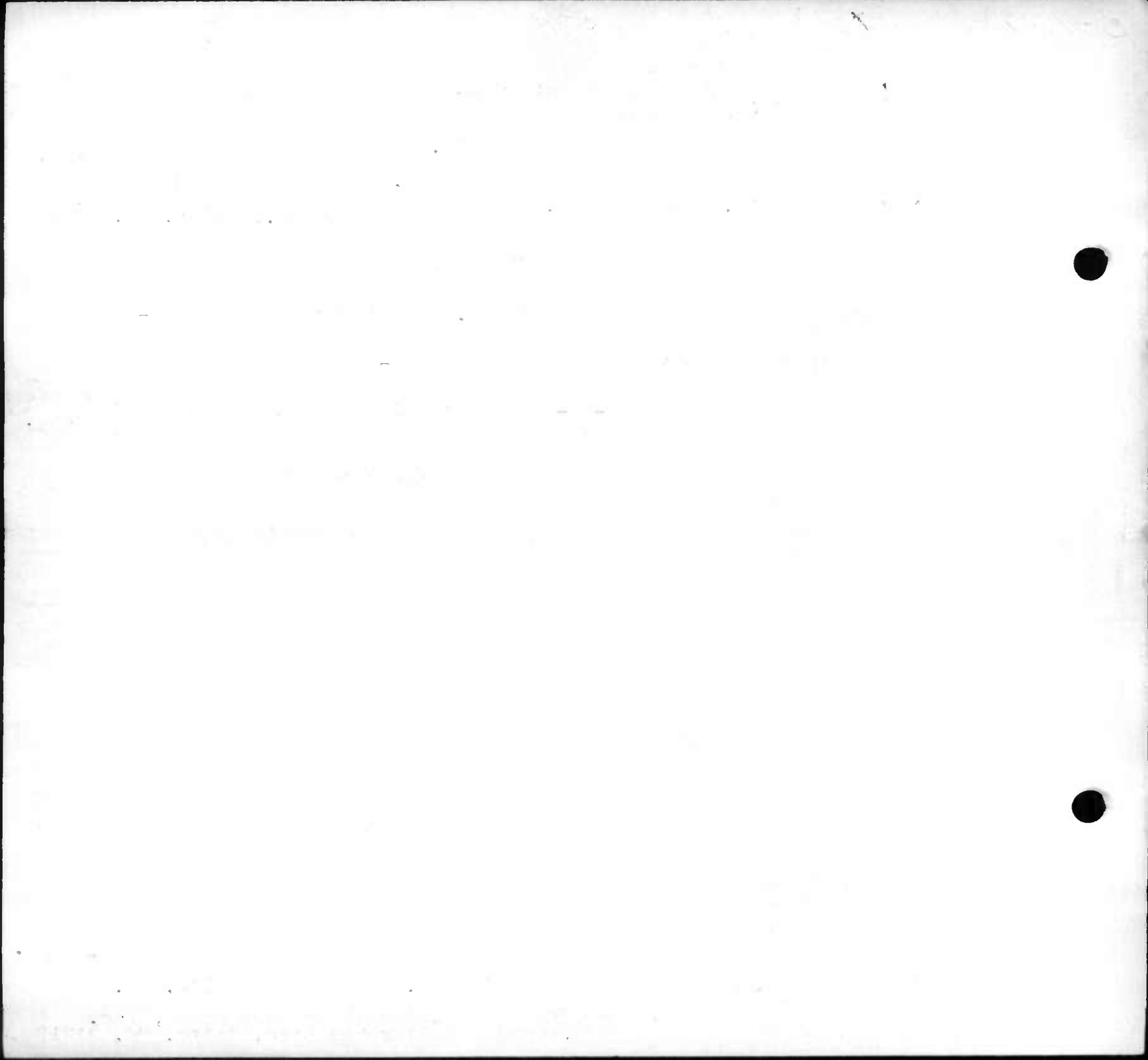
STATE OF MARYLAND - DEPARTMENT OF HEALTH		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06134	
BIRTH NO. 72 06134		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mary E. Mallon		2. DATE AND HOUR OF DEATH June 29, 1972		6:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5121 Wright Ave. Baltimore, Md. 21205			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/7/04	9. AGE (In years last birthday) 68	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretarial		10B. KIND OF BUSINESS OR INDUSTRY Monarch Rubber Co. Md.		11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Posey		14. MOTHER'S MAIDEN NAME Anna Emge			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-01-1253		17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cachexia of malignancy (B) CARCINOMA of the DUE TO, OR AS A CONSEQUENCE OF: Gall bladder (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION May 3rd 1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Gall Bladder		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/12/1972 to 6/29/1972 that (I) (we) last saw the deceased alive on 6/29/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE NIGEL D Fox		23B. DATE SIGNED 6/29/72			
23C. PHYSICIAN'S NAME (Type) NIGEL D Fox		23D. ADDRESS BCH 4940 Eastern Ave. Baltimore, Md. 21224			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/72		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Balto. Md.		24E. NAME OF REGISTRAR Sidney W. Horton		24F. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Sidney W. Horton		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06135	
CERTIFICATE OF DEATH					
BIRTH NO. 72 06135					
1. NAME OF DECEASED (Type or Print) MASON I IRON Blackway		2. DATE AND HOUR OF DEATH 6-29-72 7:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 43 South Balto. General Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2633			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Balto. General Hosp.		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3318 Ramona Ave., Balto. Md. 21213			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/27/11	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10B. KIND OF BUSINESS OR INDUSTRY American Realty Co.		11. BIRTHPLACE (State or foreign country) Delaware	
13. FATHER'S NAME Josiah Blackway		14. MOTHER'S MAIDEN NAME -			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-16-5866		17. INFORMANT Patricia Skarupa (dghtr) ADDRESS Aberdeen Ave.	
18. 162-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Ca ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Dist Col Cell Carcinoma		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Ca		(B) Dist Col Cell Carcinoma DUE TO, OR AS A CONSEQUENCE OF: -	
(C) -					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6-29-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) -	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 6-17-72 to 6-29-72 that (I) (we) last saw the deceased alive on 6-29-72 at 7:30 AM and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carlos M. Patalinghug		23B. DATE SIGNED 6-29-72 (7:30 AM)			
23C. PHYSICIAN'S NAME (Type) Carlos M. Patalinghug		23D. ADDRESS SRGH			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/1/72		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Pk. Cemetery	
24D. LOCATION Balto Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Aileen Johnston		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



T-420

STATE OF MARYLAND-DEPT

BALTIMORE CITY HEALTH DEPARTMENT

72 06136

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06136

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) WALTER TOLSKY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour June 29, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1972 7:55 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2643	
9. DATE OF BIRTH 10/6/98		10. AGE (In years lost birthday) 73 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? -	
13. FATHER'S NAME Adam Tolski		14. STREET AND NUMBER 3515 Elmore Avenue	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		14B. KIND OF BUSINESS OR INDUSTRY Continental Can Co.	
15. MOTHER'S MAIDEN NAME Emila Myslak (Mislinska)		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 215-03-3771		18. INFORMANT Alfred Uczynski (nephew) ADDRESS Framingham Rd.	
19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED June 30, 1972		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24B. DATE 7/3/72		24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972	
25B. NAME OF REGISTRAR Audrey W. Horton		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.	
25D. ADDRESS 3331 Brehms Lane, Balto. Md. 21213			

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PHYSICAL EXAMINATION REPORT

DATE: 10/10/1964

TIME: 10:00 AM

BY: DR. J. H. BROWN

RE: [illegible]

AGE: 45

SEX: M

HT: 5' 10"

WT: 180

TEMP: 98.6

PULSE: 72

BLOOD PRESSURE: 120/80

HEART: Normal

LUNGS: Clear

ABDOMEN: Soft

NECK: No lymphadenopathy

THYROID: Normal

TESTES: Normal

PROSTATE: Normal

RECTUM: Normal

SPINE: No deformity

JOINTS: No swelling

SKIN: No rash

HAIR: Normal

EYES: Normal

EARS: Normal

NOSE: Normal

THROAT: Normal

VOICE: Normal

SMELL: Normal

TASTE: Normal

GENERAL: Well

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHCN BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 06137

BIRTH NO. 72 06137

1. NAME OF DECEASED
(Type or Print)

Mahoney, Catherine M.

2. DATE AND HOUR OF DEATH

6/29/72 @ 1:35 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MD Gen'l Hosp

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

MD

C. CITY OR TOWN

BALTO

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3422 Cardenas Ave., Balto. Md. 21213

5. SEX

F

6. RACE

W

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

10/14/81

9. AGE (in years last birthday)

90

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Colo.

12. CITIZEN OF WHAT COUNTRY?

-

13. FATHER'S NAME

Adrian Marshall

14. MOTHER'S MAIDEN NAME

Mary Thompson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

523-62-6503

17. INFORMANT

Catherine Dohony (dghtr) same as above

ADDRESS

18. *412.4 I*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

16/23/72

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Bleeding

20A. AUTOPSY (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert J. Schimunek

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/29/72

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL-transit

24C. NAME of CEMETERY or CREMATORY

Lonetree Cemetery

24D. LOCATION

(City, town, or county)

Telluride, Colo.

25A. DATE REC'D BY HEALTH DEPT.

JUL 3 1972

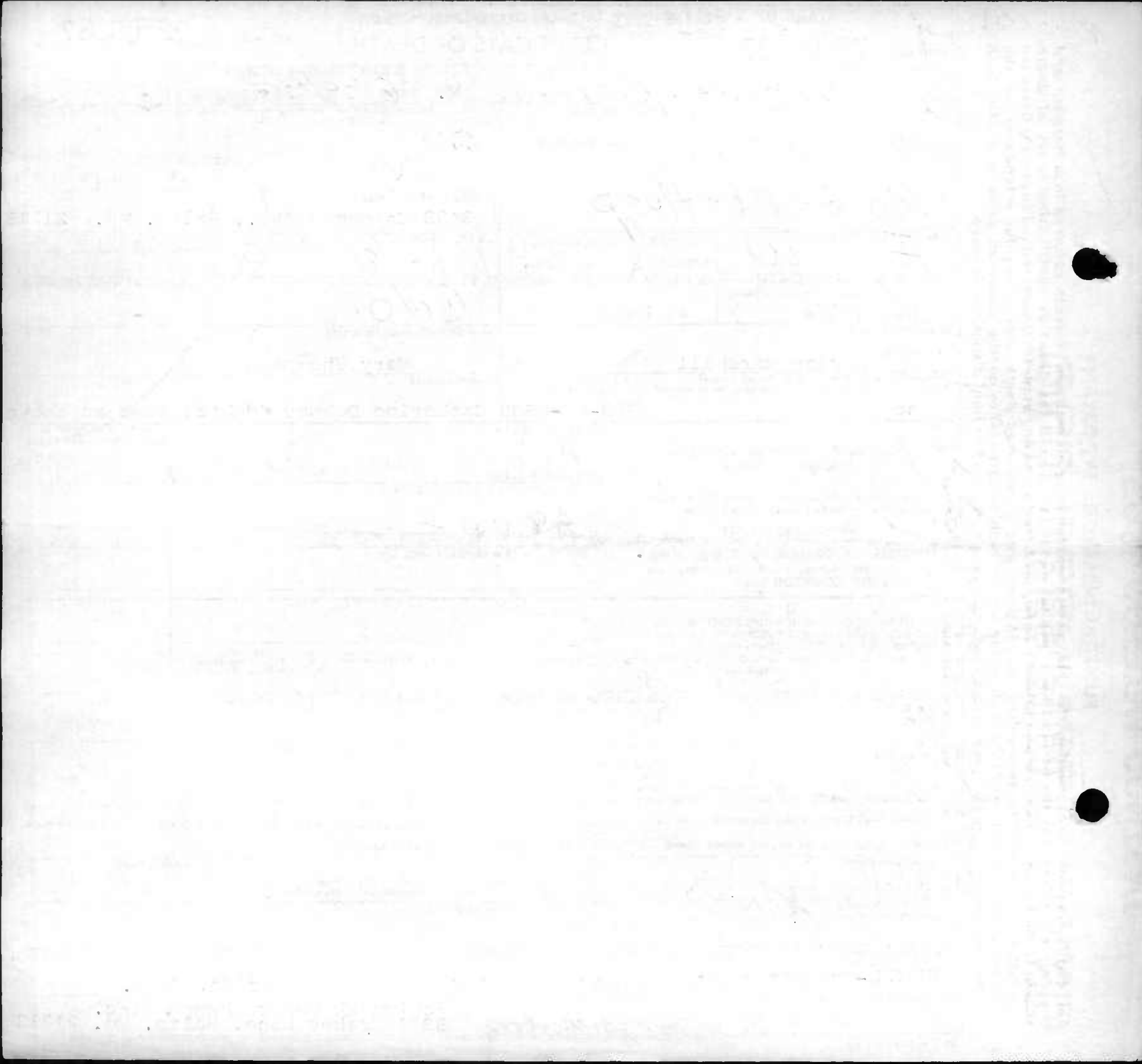
25B. NAME OF REGISTRAR

Adrian Marshall

25C. FUNERAL DIRECTOR

Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) Thomas Holmes						2. DATE AND HOUR OF DEATH 6/29/72 3 ⁵⁰ P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224						4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY Anne Arundel C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Box 465 204 th st.					
5. SEX Male		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/5/71		9. AGE (In years last birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Holmes						14. MOTHER'S MAIDEN NAME Barbara Wolfe					
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST (A) IMMEDIATE CAUSE Possible intracranial hemorrhage 20% DUE TO, OR AS A CONSEQUENCE OF: (B) Hyponatremia & u-p serum ~ 32 hr DUE TO, OR AS A CONSEQUENCE OF: remains (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/16/72 to 6/29/72 that (I) (we) last saw the deceased alive on 6/29/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Ronald G. Banks M.D. DEGREE						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6/29/72	
23C. PHYSICIAN'S NAME (Type) RONALD G. BANKS M.D. DEGREE						23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. Baltimore City Hosp.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/72		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park				24D. LOCATION (City, town, or county) (State) Glen Burnie, Anne Arundel, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS Pasadena, Md. Mc Cully Funeral Home Mt. & Tick Neck Rds.			

[Faint, illegible handwriting throughout the page]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

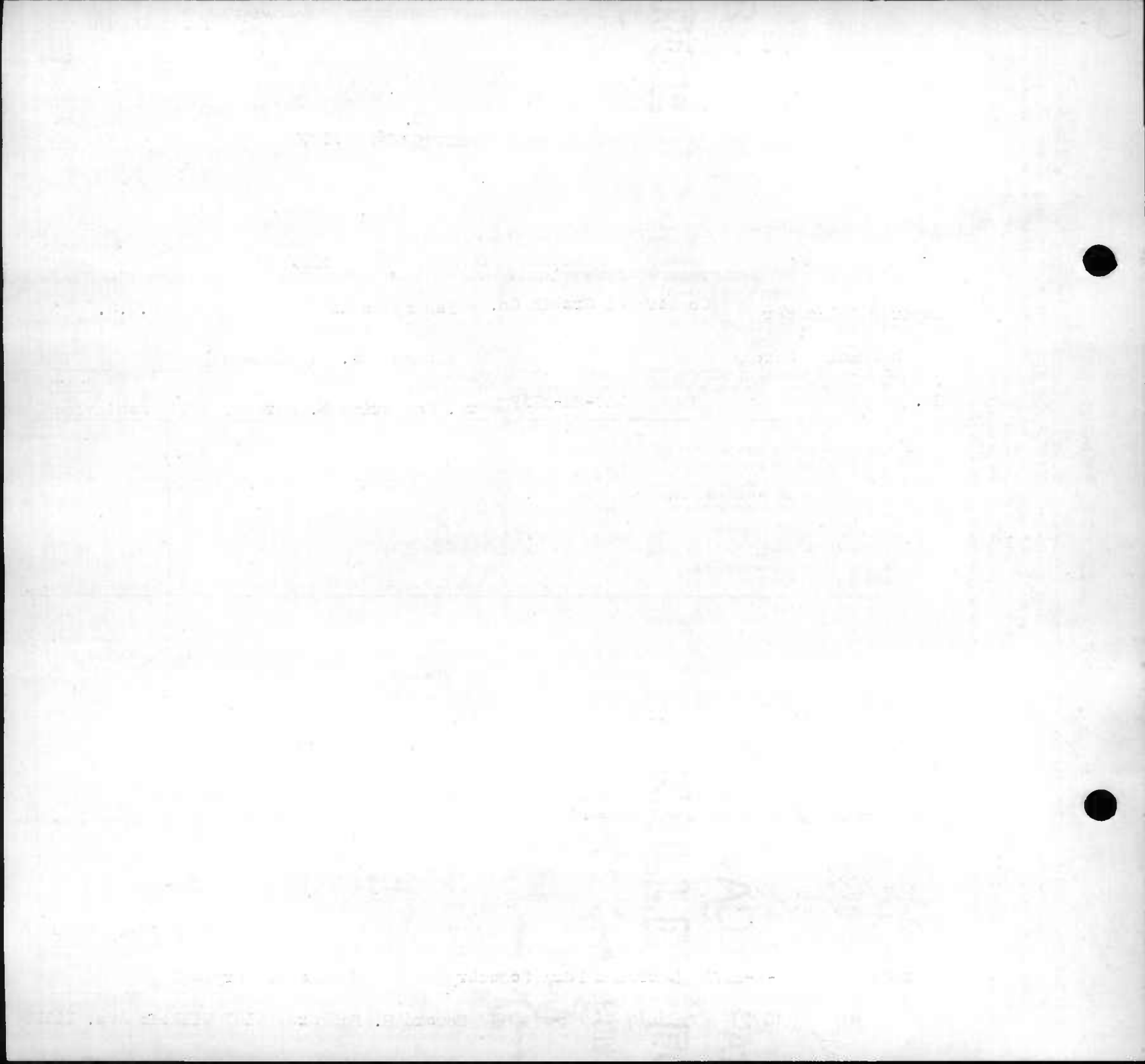
A-652

STATE OF MARYLAND - DEPARTMENT OF HEALTH				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06139	
BIRTH NO. 72 06139				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN A. ARMIGER				2. DATE AND HOUR OF DEATH June 29, 1972 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4226 Eldone Road Baltimore, Maryland 21229				A. STATE Maryland B. COUNTY 2541			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4226 Eldone Road			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-1901	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Florist			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lewis Armiger				14. MOTHER'S MAIDEN NAME Virginia Ward			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-14-7195		17. INFORMANT ADDRESS Mrs. Helen M. Armiger, 4226 Eldone Rd. 21229	
18. 433.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis (B) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 18 19 68 to June 29 19 72 , that (I) (we) last saw the deceased alive on June 28 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kennard Yaffe MD				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/29/72	
23C. PHYSICIAN'S NAME (Type) Kennard Yaffe				23D. ADDRESS 5501 Forest Park Ave., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-1972		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Audrey H. Houston		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

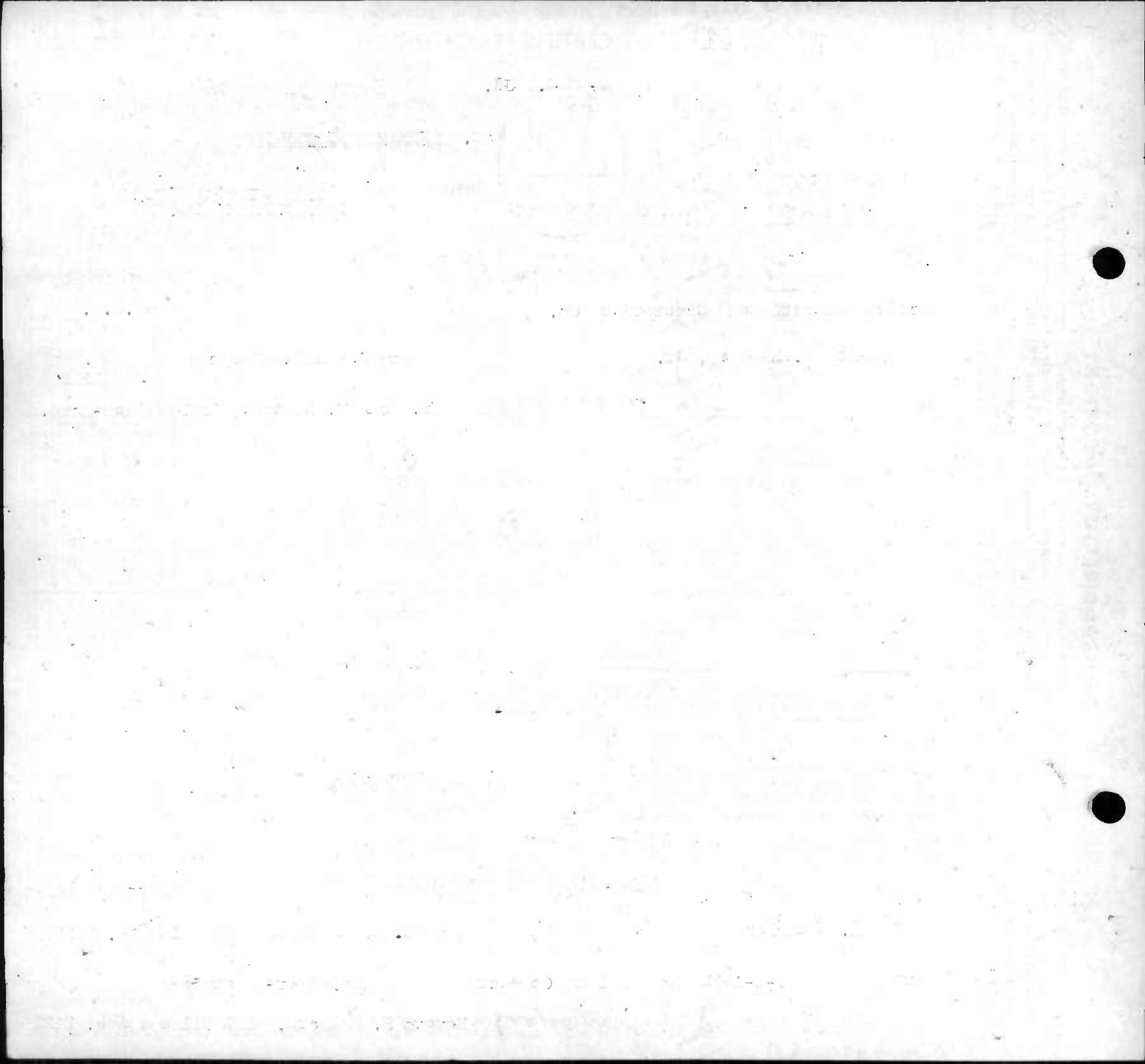
STATE OF MARYLAND-DEPT. BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 06140</u>	
72 06140				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>RAYMOND EARNHART STRONG</u>		2. DATE AND HOUR OF DEATH <u>6/27/72</u> <u>1:15 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>XXXX</u>		2102	
FULL NAME OF HOSPITAL OR INSTITUTION <u>U. of Md. HOSPITAL</u> <u>38</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1114 WASHINGTON BLVD.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>08/17/07</u>	9. AGE (In years last birthday) <u>XXXX</u> 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Collector</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Commercial Credit Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Emanuel Strong</u>		14. MOTHER'S MAIDEN NAME <u>Blanch R. (Unknown)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>218-03-1759</u>		17. INFORMANT <u>Mrs. Catherine E. Strong, 1114 Washington Blvd</u>	
				ADDRESS <u>21230</u>	
18. <u>519.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>NATURAL CAUSES</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/14/59</u> 19 to <u>9/23/59</u> 19, that (I) <u>(we)</u> last saw the deceased alive on <u>06/08</u> 19 <u>72</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>A. Andrew Metzger</u>				23B. DATE SIGNED <u>06/28/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>G. ANDREW METZGER</u>				23D. ADDRESS <u>3914 NOYES CIRCLE, RANDALLSTOWN, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-1-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL. 3 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Metzger</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

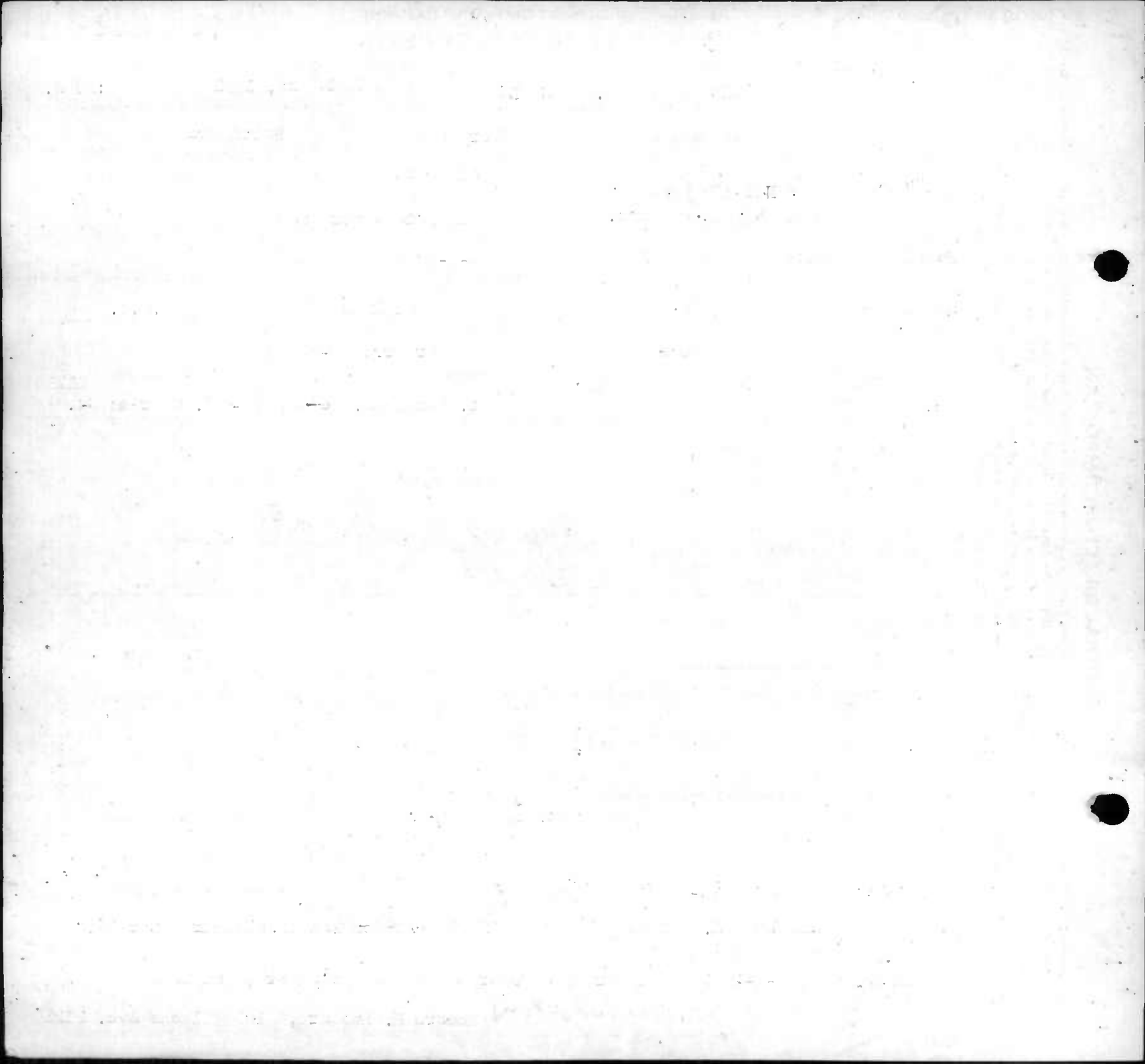
STATE OF MARYLAND - DEPARTMENT OF HEALTH				BALTIMORE CITY HEALTH DEPARTMENT	
72 0614T				CERTIFICATE OF DEATH	
BIRTH NO.				REG. NO. 72 0614T	
1. NAME OF DECEASED (Type or Print) <u>Livesay, William A., JR.</u>				2. DATE AND HOUR OF DEATH <u>6/28/72 4:42</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Catox Manor Nursing Home</u> <u>Wilkes + Catox Avenues</u>				A. STATE <u>MD.</u> B. COUNTY <u>2551</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER <u>3543 WILKENS AVENUE</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Electrician</u>				8. DATE OF BIRTH <u>10-20-93</u> 9. AGE (In years last birthday) <u>78</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>Enterprise Co.</u>				11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>William A. Livesay, Sr.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Burgess</u>	
16. SOCIAL SECURITY NO. <u>212-03-2303</u>				17. INFORMANT ADDRESS <u>21229 Mr. John T. Livesay, 3543 Wilkens Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>412.4 I</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CUA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASUUD</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>	
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (qualify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 6 1972</u> to <u>June 28 1972</u> that (I) <u>last</u> last saw the deceased alive on <u>6/28</u> 19 <u>72</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Earl Pass</u>				23B. DATE SIGNED <u>6/28/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>I. Earl Pass</u>				23D. ADDRESS <u>4001 Wilkens Avenue, Baltimore, Md. 21229</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>7-1-1972</u>		<u>Loudon Park Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<u>JUL 3 1972</u>		<u>Adrian Houston</u>		<u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

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STATE OF MARYLAND-DHMH BALTIMORE CITY HEALTH DEPARTMENT									
72 06142					REG. NO. 72 06142				
BIRTH NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) MARIE A. EARLE					JUNE 28, 1972 7:50 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Hood Nursing Home 5313 Edmondson Ave.					Maryland Baltimore				
					C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 813 Dorchester Road				
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-1896	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Demek			14. MOTHER'S MAIDEN NAME Margaret Meckle						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Martin A. Demek, 1708 S. Charles St.		ADDRESS 21230		
18. 250.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardio-respiratory failure</i> (B) <i>Cerebral Vascular Thrombosis</i> (C) <i>Diabetes</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June</i> 19 <i>70</i> to <i>28 June</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>28 June</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>William J. Bryson</i>					23B. DATE SIGNED <i>29 June 72</i>				
23C. PHYSICIAN'S NAME (Type) William J. Bryson					23D. ADDRESS 5772 Westview Mall, Baltimore, Maryland				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 7-1-1972		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972			25B. NAME OF REGISTRAR <i>Andrew H. Hubbard</i>			25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			ADDRESS



72 06143

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06143

BIRTH NO.

REG. NO.

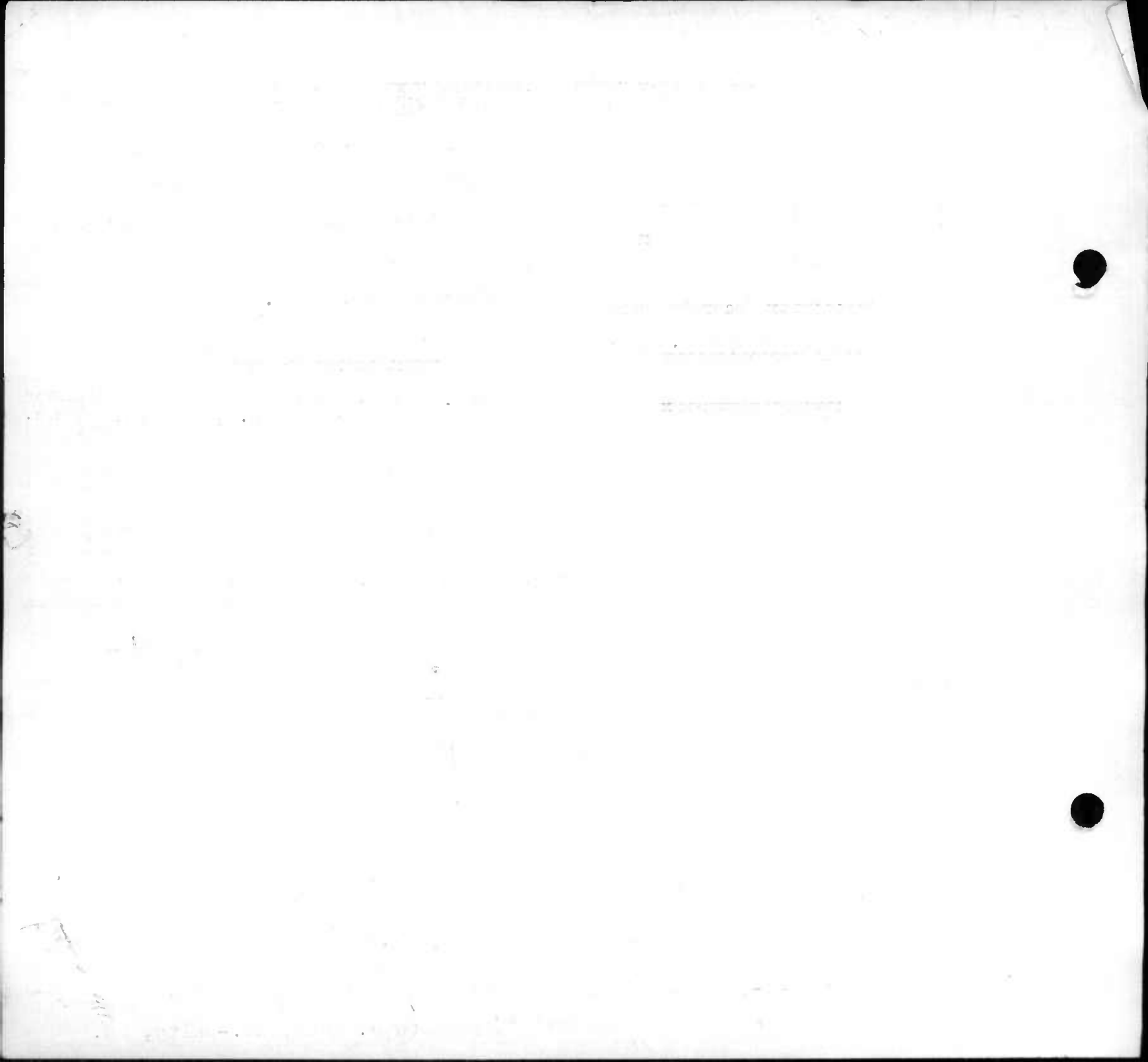
1. NAME OF DECEASED (Type or Print) HUGH G. MacDonald, Jr. HUGH MAC DONALD, Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour June 29, 1972	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1972 9:00 P.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/5/34		10. AGE (In years lost birthday) 37	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1953		17. SOCIAL SECURITY NO. 215-30-9769	
15. MOTHER'S MAIDEN NAME HILDA L. FITCH		18. INFORMANT Hugh G. MacDonald, Sr. (father)	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Shotgun wound of head		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Tavern	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 6-29-72 7:56 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2745 Greenmount Avenue		22F. HOW DID INJURY OCCUR? Shot after altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DATE SIGNED June 30, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/3/72	
24C. NAME OF CEMETERY or CREMATORY LORRAINE		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Arday W. Horton	
25C. FUNERAL DIRECTOR Paul E. Chonow		ADDRESS 3617 Chestnut Ave.	

7/18/72 - Correction form from funeral director.

Lgc.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DISTRICT OF COLUMBIA		BALTIMORE CITY HEALTH DEPARTMENT	
Paul Jefferson McDade		72 06144	
(MCDADE)		72 06144	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>PAUL J. MCDADE</u>		2. DATE AND HOUR OF DEATH <u>6/29/72</u> <u>1045 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>774 WASHINGTON BLVD.</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/18</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Guard</u>		9. AGE (In years last birthday) <u>54</u>	11. BIRTHPLACE (State or foreign country) <u>Chattanooga, Tenn.</u>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. McDade</u>		14. MOTHER'S MAIDEN NAME <u>Dollie Daughtery</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Mrs. Pauline Burns (sister)</u>		ADDRESS <u>Hickson Rt. 2, Levi Rd, Tenn.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Renal FAILURE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>HEPATIC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>10 DAYS</u>	
(C) <u>CHRONIC ALCOHOLISM</u>		—	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>NONE</u>		—	
19A. DATE OF OPERATION <u>6/29</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/29</u> 19 <u>72</u> to <u>6/29</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6/29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Paul D. Light M.D.</u>		23B. DATE SIGNED <u>6/29/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>PAUL D. LIGHT M.D.</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>7-5-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Ball Hill Cem'ty</u>		24D. LOCATION (City, town, or county) (State) <u>Birchwood, Tenn.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Johnston</u>	
25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc.-Balto, Md.</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT				72 06145	
72 06145				CERTIFICATE OF DEATH	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JOHN Joseph HOFFMAN		6/28/72 8.40pm			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCY (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		A. STATE MARYLAND		B. COUNTY 1203	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2726 N. CALVERT ST. 2918 HUNTINGDON AVE			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11, 1910	9. AGE (In years last birthday) 62	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MARTIN Hoffman		14. MOTHER'S MAIDEN NAME Catherine Kohler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 220-05-8505		17. INFORMANT Catherine Kueberth Arnold, Md. 21012	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) I 503.21 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) SEPSIS DUE TO, OR AS A CONSEQUENCE OF: (C) CHRONIC ALCOHOLIC		19. DATE OF OPERATION 1972		20. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-20 1972 to 6-28 1972, that (I) (we) last saw the deceased alive on 6-28 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE JUAN M. CALDERON		23B. DATE SIGNED 6-28-72			
23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON M.D.		23D. ADDRESS SAME			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1 July 1972		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem.	
24D. LOCATION Glen Burnie AA, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Sidney W. Horton	
25C. FUNERAL DIRECTOR Robert S. Barranco FH		25D. ADDRESS Ritchie Hwy Severna Park Md.			

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPT. OF HEALTH				Baltimore City Health Department	
BIRTH NO. <u>7260003605</u>				REG. NO. <u>72 06146</u>	
1. NAME OF DECEASED (Type or Print) <u>Belschner, Hilda M.</u>			2. DATE AND HOUR OF DEATH <u>6-30-72</u> <u>6:50 PM</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>1207</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>CERTIFICATE AMENDED</u> <u>48827 Linden Avenue</u> <u>Baltimore, md. 21201</u> <u>7-11-72</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>340 W. 29th St.</u>			5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			8. DATE OF BIRTH (In years last birthday) <u>06/03/05</u> <u>67</u>		9. AGE (In years last birthday) <u>67</u>
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-09-3721</u>		17. INFORMANT <u>EMILIE ALTHOFF 826 W. 32nd ST.</u>	
18. <u>56211</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Renal failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Peritonitis</u> <u>Ruptured diverticulum</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>16/15/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Peritonitis</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/13/72</u> 19 <u>72</u> to <u>6/30</u> 19 <u>72</u> that (I) (We) last saw the deceased alive on <u>6/30</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kristin Stiebor MD</u> MD				23B. DATE SIGNED <u>6/30/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>KRISTIN STIEBOR MD</u>				23D. ADDRESS <u>MD GENERAL HOSP</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/3/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>	
24D. LOCATION (City, town, or county) <u>BALTO. M.D.</u>		24E. STATE <u>MD</u>		24F. ZIP CODE <u>21201</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1972</u>		25B. NAME OF REGISTRAR <u>Anthony J. Keston</u>		25C. FUNERAL DIRECTOR <u>Paul E. Keston</u>	
25D. ADDRESS <u>3612 Chestnut Ave.</u>		25E. CITY, STATE, ZIP CODE <u>BALTO. MD. 21201</u>			

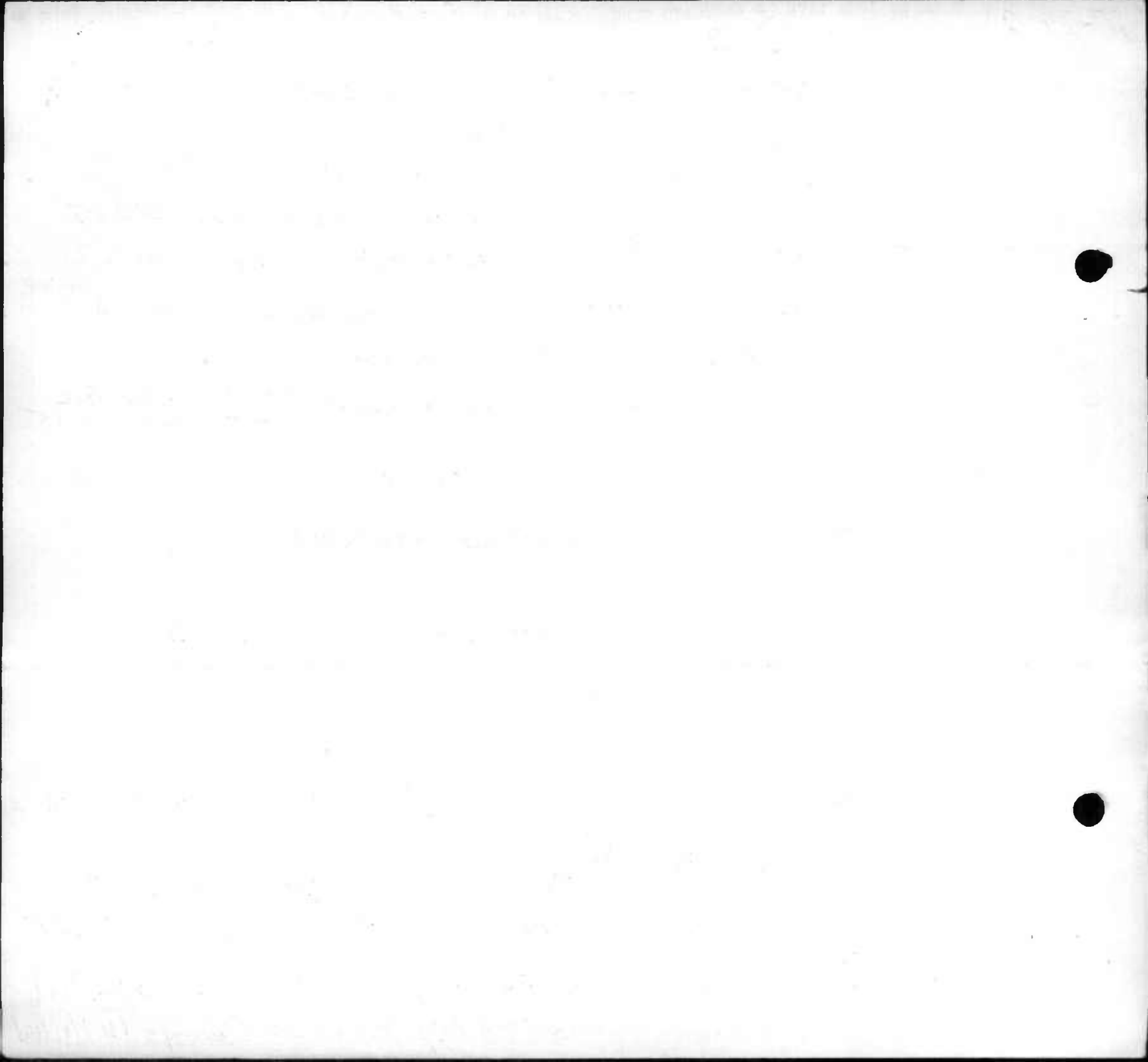
7-11-1972 - Letter from Maryland General Hospital, 827 Linden Avenue, Balto., Md.

Medical Records Department
Mrs. G. Nash

HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEMO BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06147	
72 06147				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MACK, MABEL Irene		2. DATE AND HOUR OF DEATH 6-28-72 8:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2798		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4916 CORDELIA AV. 21215		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-2-1920	9. AGE (In years last birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leon Paul Newsome Sr.		14. MOTHER'S MAIDEN NAME Mabel White	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 075-20-2754		17. INFORMANT Philip Mack ADDRESS 4916 Cordelia Ave. Balto. Md. 21215	
18. 442X1 CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE CVA DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) BLEEDING ANEURYSM DUE TO, OR AS A CONSEQUENCE OF:		
			(C) —		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HYPERTENSIVE CARDIOVASCULAR D.					
19A. DATE OF OPERATION 6-14-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Notify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-14-72 to 6-28-72 that (I) (we) last saw the deceased alive on 6-28-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter Oroszlan MD		23B. DATE SIGNED 6-28-72		23C. PHYSICIAN'S NAME (Type) PETER OROSZLAN MD	
23D. ADDRESS 3 HATILL RD APTS 5, 21210					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 3, 1972		24C. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery	
24D. LOCATION Reisterstown, Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Sidney W. Horton		25C. FUNERAL DIRECTOR H. J. Schlandt Owings Mills, Md.	



FUNERAL DIRECTOR: IMPORTANT

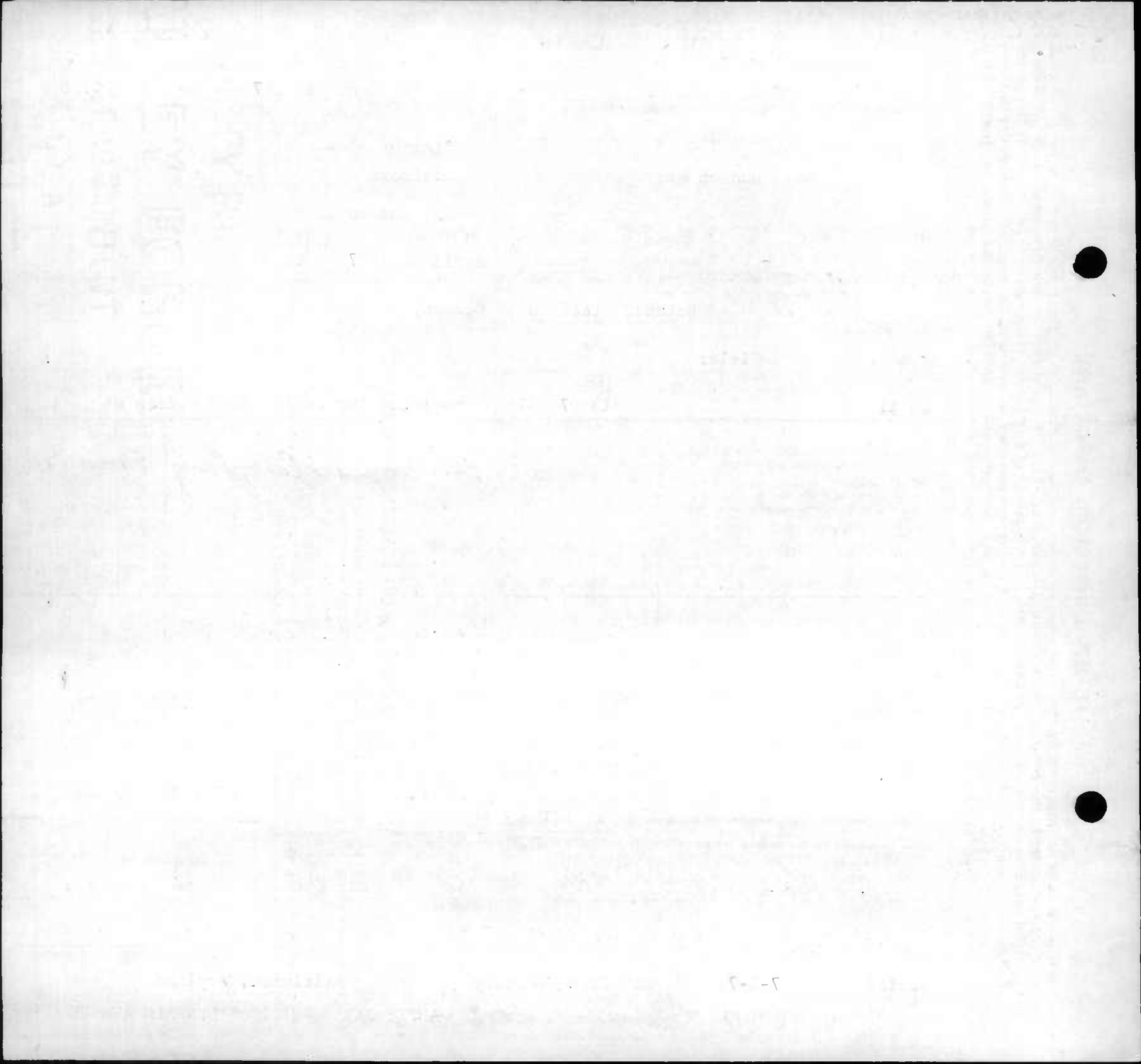
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-4601

STATE OF MARYLAND - DEPT. OF HEALTH
BALTIMORE CITY HEALTH DEPARTMENT
72 06148
CERTIFICATE OF DEATH

REG. NO. 72 06148

BIRTH NO. 72 06148		2. DATE AND HOUR OF DEATH June 28 - 1972 9:30 P.M.	
1. NAME OF DECEASED (Type or Print) Ludwig C Wieler		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 6623 Hudson St		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20 1907
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Bethel, Steel Co	9. AGE (In years last birthday) 65
13. FATHER'S NAME ? Wieler		11. BIRTHPLACE (State or foreign country) Germany	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WW 11		16. SOCIAL SECURITY NO. 213 07 4578	12. CITIZEN OF WHAT COUNTRY? U S A
17. INFORMANT Charlotte Guerrasio		ADDRESS 6623 Hudson St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Bronchopneumonia of Lung (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Urinary Infection			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-6-72 to 6-28-72 that (I) (we) last saw the deceased alive on 6-25-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John Constantini M.D.		23B. DATE SIGNED 6-30-72	
23C. PHYSICIAN'S NAME (Type) JOHN CONSTANTINI, M.D.		23D. ADDRESS 234 S. CONKLING ST	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-1-72	
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Andrew H. Weston	
25C. FUNERAL DIRECTOR WALTER DABROWSKI		ADDRESS 1005 DUNDALK AVENUE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEMO BALTIMORE CITY HEALTH DEPARTMENT
72 06148 CERTIFICATE OF DEATH

BIRTH NO. 72 06148 REG. NO. 72 06148

1. NAME OF DECEASED (Type or Print) Albert IDA		2. DATE AND HOUR OF DEATH 6/26/72 5:20 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL OF BALTIMORE 42		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01/20/1902 9. AGE (In years last birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		11. BIRTHPLACE (State or foreign country) BRONX NEW YORK	
13. FATHER'S NAME SAMUEL SHERMAN		14. MOTHER'S MAIDEN NAME BERTHA EUGENE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 125-385712	
18. 410.941-2309 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: 3 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes, Cholelithiasis			
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
22. I certify that (1) (this hospital) attended the deceased from 6/25 19 72 to 6/26 19 72 that (2) (we) last saw the deceased alive on 6/26 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
23A. SIGNATURE Lawrence Solomon		23B. DATE SIGNED 6-26-72	
23C. PHYSICIAN'S NAME (Type) LAWRENCE SOLOMON		23D. ADDRESS 3600 LOCKHART DR.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/27/72	
24C. NAME OF CEMETERY OR CREMATORY NEW MONTEFIORE PINE LAWN NY		24D. LOCATION (City, town, or county) (State) BLVD	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Andrew Johnson	
25C. FUNERAL DIRECTOR William Johnson		ADDRESS 8521 LOCH RAVEN	

VS 150-REV. 1/1/68

BRONX NEW YORK

WILLIAM J. BROWN 221 W. 11th St. New York N.Y.
10011-10011

CERTIFICATE OF DEATH

REG. NO.

72 06150

BIRTH NO.

72 06150

1. NAME OF DECEASED

(Type or Print)

Mr. Frank Harr

2. DATE AND HOUR OF DEATH

June 26, 1972

6:41

P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATIONBaltimore City Hospital
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Pennsylvania

C. CITY OR TOWN

York

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

119 Dill Rd.

5. SEX

M

6. RACE

Cauc.

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

9-21-13

9. AGE (In years
last birthday)

58

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Installer Sean Rollins

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

XXXX U.S.A.

13. FATHER'S NAME

Frank Harr

14. MOTHER'S MAIDEN NAME

Caroline Kessner

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) If yes, give war or dates of service16. SOCIAL
SECURITY NO.

232-22-547

17. INFORMANT

ADDRESS

BCH RECORDS: 4940 Eastern Avenue

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) slowing the
UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Squamous Cell
Metastatic Carcinoma of LungAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 mon.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (A) (this hospital) attended the deceased from May 31, 1972 to June 26, 1972
that (B) (we) last saw the deceased alive on June 26, 1972 and that (C) (our) opinion death occurred on the date
and hour and from the causes stated above. (D) (We) (did) (not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

Robert Jacobs M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6/26/72

23D. ADDRESS

Baltimore City Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 3 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U.S.A.

335-55-2147
Baroque Treasures
1501 W. Market St.

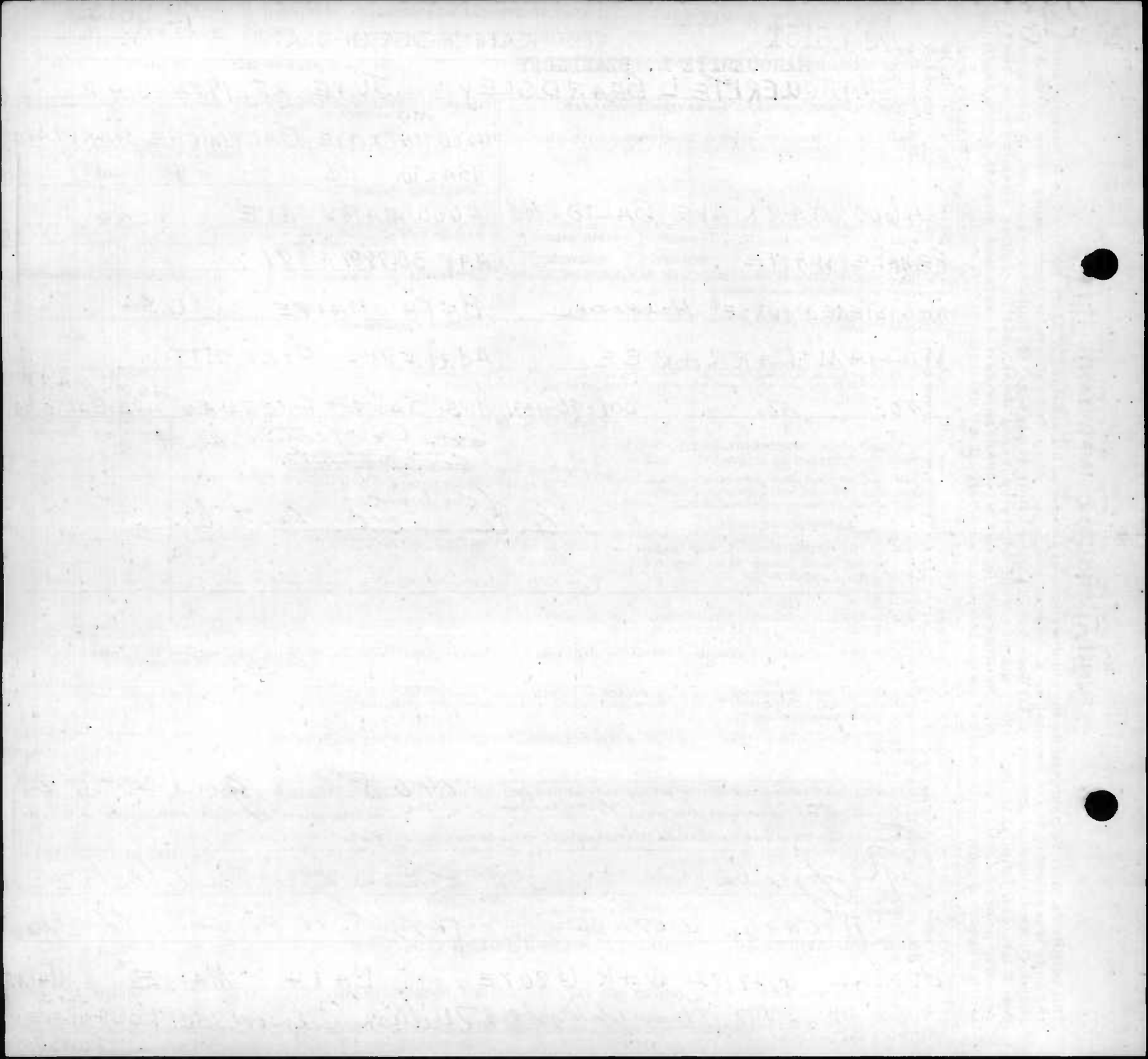
Photostat 2000

Baroque Treasures
1501 W. Market St.
William Johnson 8254 Loch Raven
Bldg

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - BALTIMORE CITY HEALTH DEPARTMENT				72 06151	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. 72 06151					
1. NAME OF DECEASED (Type or Print) MARGUERITE L. BEARDSLEY		2. DATE AND HOUR OF DEATH JUNE 25, 1972 6 AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD B. COUNTY			
H600 MARK AVE BALTO, MD		C. CITY OR TOWN BALTO, MD D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 4600 MARK AVE		2632			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 30, 1891	9. AGE (In years last birthday) 81	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REGISTERED NURSE		10B. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) BATH MAINE	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM LARRABEE		14. MOTHER'S MAIDEN NAME ADRIANNA FICKETT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. 004-20-4391		17. INFORMANT MRS. JANET FREEMAN	
18. 4/23/31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: failure			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis heart disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1968 to June 25, 1972, that (I) (we) last saw the deceased alive on June 22, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
RICHARD LOZADA		6/26/72		23D. ADDRESS 1225 S. Ches St. Balt - 1203	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		6/29/72		OAK GROVE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 3 1972		Sidney Johnston		William Johnson	
				ADDRESS 8521 LOCH RAVEN TOWSON	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DISTRICT OF BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 72 06152		CERTIFICATE OF DEATH		REG. NO. 72 06152	
1. NAME OF DECEASED (Type or Print) RUNYON, BROOKIE				2. DATE AND HOUR OF DEATH 6-28-1972 6:09 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md - Balto - B. COUNTY 3604 Elm Ave 1306					
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 33rd & Calvert					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01-09-16		9. AGE (In years last birthday) 56		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME HALFORD RUNYON				14. MOTHER'S MAIDEN NAME NANNIE EVANS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Katherine Runyon			
						ADDRESS 3604 Elm Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Terminal Carcinoma				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Terminal Carcinoma					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cancer in the liver & metastases				(B) DUE TO, OR AS A CONSEQUENCE OF: Asepsis & Asepsis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2-19-72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5-26-1972 to 6-28-1972 , that (I) (we) lost saw the deceased alive on 6-28-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]				23B. DATE SIGNED 6-28-1972					
23C. PHYSICIAN'S NAME (Type) Shoshon Nahas M.D.				23D. ADDRESS Union Memorial Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 30 June 72		24C. NAME OF CEMETERY OR CREMATORY Mays Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Lutherville, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972				25B. NAME OF REGISTRAR Sidney H. Weston		25C. FUNERAL DIRECTOR Burgee Funeral Home		ADDRESS Baltimore, Md.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SPAMER COHEN

2. DATE AND HOUR OF DEATH

JUNE 29, 1972 2:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL, BALTO., MD. 21215

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

MARYLAND

C. CITY OR TOWN

BALTO.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

MD. - 4016 FORDS LANE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

3/28/94

9. AGE (In years last birthday)

78

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

XXXXXXXXXX TAILOR

10B. KIND OF BUSINESS OR INDUSTRY

XXXXXXXXXX SHOP

11. BIRTHPLACE (State or foreign country)

XXXXXXXXXX LITHUANIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

AARON COHEN

14. MOTHER'S MAIDEN NAME

HYAH

?

XXXXXXXXXX

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

MRS. FLORENCE EISEMAN

ADDRESS

XXXXXXXXXX 4016 FORDS LANE, APT. 1 C

XXXXXXXXXX

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

CARCINOMA TOBIS

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIO - RESPIRATORY

(B)

DUE TO, OR AS A CONSEQUENCE OF:

EMACIATION & DEHYDRATION

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

ASPIRATION PNEUMONIA

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/1/72 to 6/29/72 that (I) (we) last saw the deceased alive on 6/29/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

XXXXXXXXXX, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/29/72

23C. PHYSICIAN'S NAME (Type)

XXXXXXXXXX T. DIZON, M.D.

23D. ADDRESS

SINAI HOSP., BALTO., MD. 21215

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

6/30/72

24C. NAME OF CEMETERY or CREMATORY

BETH TFILOH

24D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 3 1972

25B. NAME OF REGISTRAR

XXXXXXXXXX

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

ADDRESS

ADMINISTRATIVE
SECTION
OFFICE
OF THE
DIRECTOR
GENERAL
OF THE
ARMY
AND
NAVY
DEPARTMENT
WASHINGTON
D. C.

RECEIVED
JAN 10 1918
U. S. DEPT. OF THE ARMY
OFFICE OF THE
DIRECTOR
GENERAL
WASHINGTON
D. C.

72 06158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 06158

BIRTH NO.

1. NAME OF DECEASED (Type or Print) IDA WEINER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> June 29, 1972 3:40 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 91 Levindale Nursing Home		3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1972 3:40 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2788	
9. DATE OF BIRTH JULY 4, 1886		10. AGE (In years last birthday) 85	
11. BIRTHPLACE (State or foreign country) RUMANIA		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		14B. KIND OF BUSINESS OR INDUSTRY AT HOME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 219-26-1163A	
18. INFORMANT ADDRESS MRS. DORIS ROMBRO, 6506 STEEREORTH COURT #9		15. MOTHER'S MAIDEN NAME MOLLIE ?	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease, probable sepsis, and possible digitalis toxicity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
Head injury		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Levindale Nursing Home	
22D. TIME OF INJURY (APPROX.) 6-18-72 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Fell out of bed		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED June 29, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/30/72	
24C. NAME OF CEMETERY or CREMATORY OHR KNESSETH ISRAEL ANSHE SFARD, BALTIMORE, MARYLAND		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Audrey Johnston	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	

100-35-1163

100-35-1163

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100-35-1163

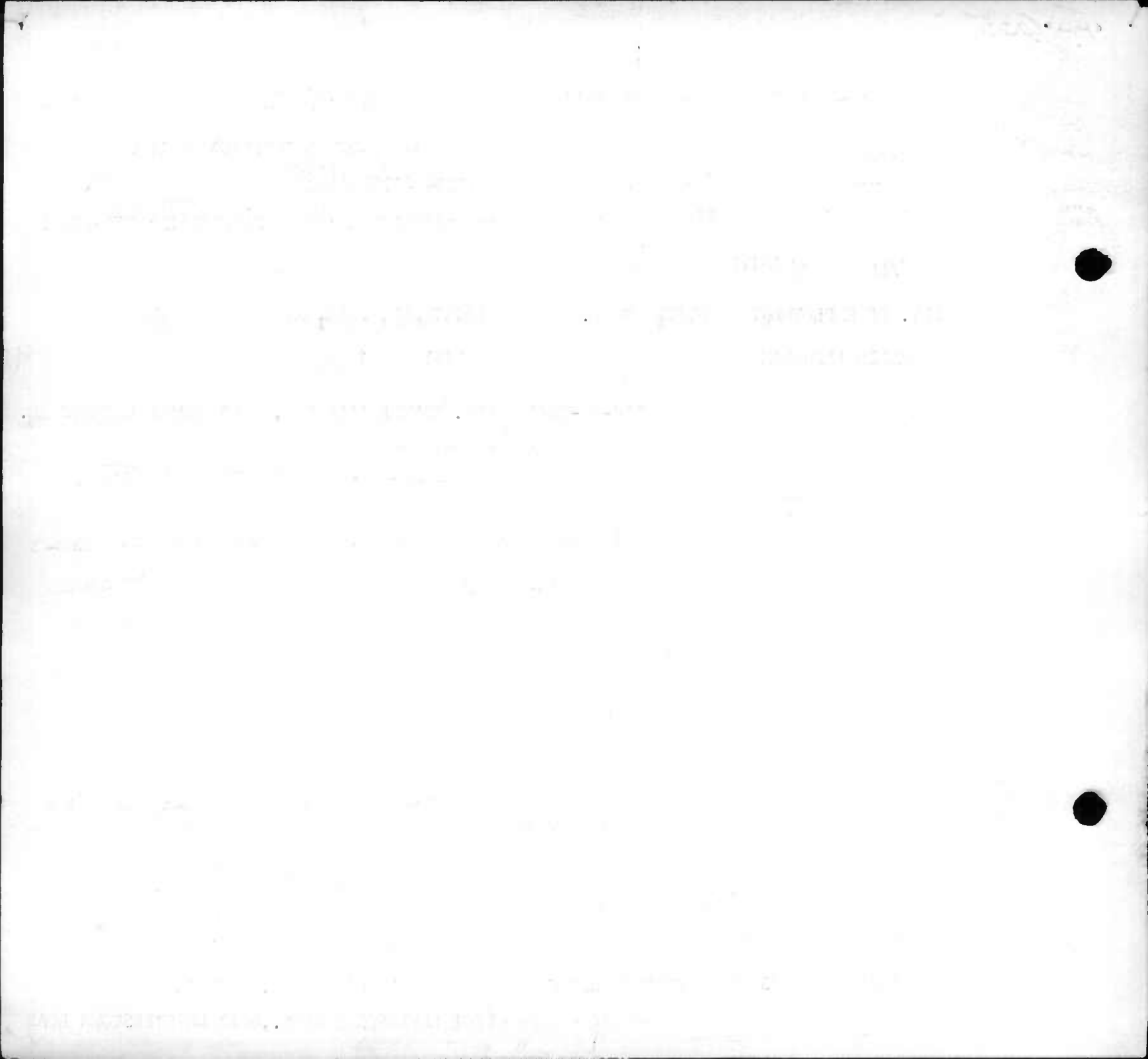
100-35-1163

100-35-1163

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT				72 06155		CERTIFICATE OF DEATH		REG. NO. 72 06155	
BIRTH NO. 72 06155				1. NAME OF DECEASED (Type or Print) RAYMOND FREEDMAN		2. DATE AND HOUR OF DEATH 6/29/72 1 03⁴⁰ AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINGAI HOSPITAL BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN RANDALLSTOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINGAI HOSPITAL BALTIMORE, MARYLAND				E. STREET AND NUMBER 9008 MEADOW HEIGHTS ROAD		F. ZIP CODE 21103			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/72	9. AGE (in years last birthday) 64	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEPT. OF EMPLOYMENT STATE OF MD.			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME HARRIS FREEDMAN			14. MOTHER'S MAIDEN NAME MARY ?						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 214-20-5841		17. INFORMANT ADDRESS MRS. EDYTHE FREEDMAN, 9008 MEADOW HEIGHTS RD.				
18. 4 10 9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARDIO-RESPIRATORY DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE MYOCARDIAL INFARCTION				(A) IMMEDIATE CAUSE DEPRESS DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30'			
				(B) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: 20 DAYS		(C) ASCUD YEARS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 6/29/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/29/72 19 72 to 6/29 19 72 that (I) (we) last saw the deceased alive on 6/29/72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]				23B. DATE SIGNED 6/29/72					
23C. PHYSICIAN'S NAME (Type) RICHARD RUTZ				23D. ADDRESS SINGAI HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/30/72		24C. NAME OF CEMETERY OR CREMATORY BNAI JACOB		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS.		ADDRESS 6010 REISTERSTOWN ROAD			



72 06156

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 06156

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROSE STARR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 116 South Patterson Park Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour June 24, 1972 11:25 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH JULY 13, 1902		10. AGE (In years last birthday) 69 XXX	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		14B. KIND OF BUSINESS OR INDUSTRY AT HOME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT MR. STANLEY RANKELL, 11937		ADDRESS LOS ANGELES, CALIF. 90049	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. DATE SIGNED June 25, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/29/72	
24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Sidney B. Howard	
25C. FUNERAL DIRECTOR COL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	

72 06157

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 06157

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEON DAHNE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 31 S. Calvert Street		3. DATE PRONOUNCED DEAD Month Day Year Hour June 27, 1972 5:29 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2/21/1903		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years (9) lost birthday) 67		E. STREET AND NUMBER 15 Cobblestone Ct. COBBLESTONE COURT, APT. 1C	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY DAHNE		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JEWELER	
14B. KIND OF BUSINESS OR INDUSTRY WHOLESALE		15. MOTHER'S MAIDEN NAME GERTRUDE LENA GARONZIK	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II		17. SOCIAL SECURITY NO. 213-28-8467	
18. INFORMANT MR. ALEX GINSBERG, 954 MD. NAT. BANK BLDG. #2		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) EYSSK Gunshot wound of head		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Office Bldg.	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 31 S. Calvert Street		22F. HOW DID INJURY OCCUR? Self-inflicted	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 6-27-72 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. DATE SIGNED 6/28/72 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/29/72	
24C. NAME OF CEMETERY or CREMATORY SHAAREI ZION		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Andrew W. ...	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	

CONFIDENTIAL - SECURITY INFORMATION

1/21/68

HARRY LAMAR

100

WALLACE, W.

UNITED STATES DEPARTMENT OF JUSTICE

MEMORANDUM

TO THE DIRECTOR

FROM: SAC, NEW YORK (100-100000) (P)

RE: [illegible]

WALLACE, W.

CONFIDENTIAL - SECURITY INFORMATION

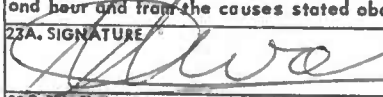
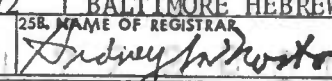
SHARPE, TIG

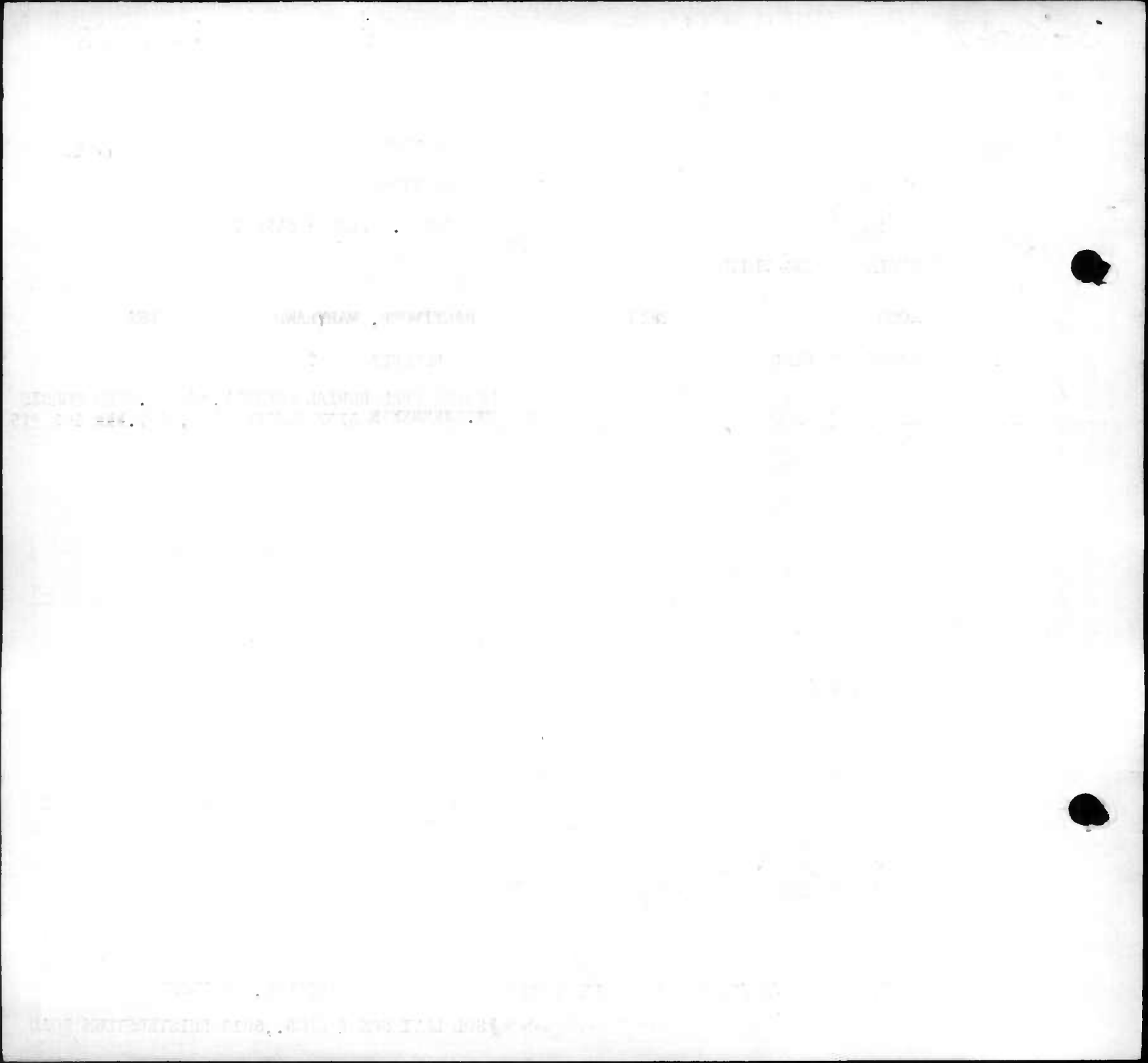
100-100000

CONFIDENTIAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPT. BALTIMORE CITY HEALTH DEPARTMENT				72 06158		72 06158	
BIRTH NO.				72 06158		REG. NO.	
1. NAME OF DECEASED (Type or Print) SARAH BRESSLER				2. DATE AND HOUR OF DEATH JUNE 28, 1972 4 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE INC. 42				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2003 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 433 S. PULASKI STREET			
5. SEX FEMALE	6. RACE XXX WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/04/14		9. AGE (in years last birthday) 58	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY BRESSLER				14. MOTHER'S MAIDEN NAME REBECCA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS HEBREW FREE BURIAL SOCIETY, c/o MR. MOSE MORRIS 3737 CLARKS LANE, APT. 101 #15			
18. 455X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE ? PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF: OR MYOCARDIAL INFARCTION (B) POST OP. HEMORRHOIDECTOMY DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). MENTALLY RETARDED				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 6/21/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HEMORRHOIDS		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/19 19 72 to 6/28 19 72 that (I) (we) last saw the deceased alive on 6/28 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED 6/28/72		23C. PHYSICIAN'S NAME (Type) DANIEL MIRELMAN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/29/72		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPARTMENT OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT

72 06158

CERTIFICATE OF DEATH

REG. NO.

72 06158

BIRTH NO.

1. NAME OF DECEASED

Type or Print

Bernstein, Joseph

2. DATE AND HOUR OF DEATH

6-27-72 2:15 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CERTIFICATE AMENDED
Singer Hospital
Belvedere @ Greenspring

3900 N. Charles St

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

Baltimore Md.

21218

1201

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-23-97

9. AGE (In years last birthday)

75

If Under 1 Yr. Months

Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Attorney

10B. KIND OF BUSINESS OR INDUSTRY

SELF EMPLOYED

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

DAVID BERNSTEIN

14. MOTHER'S MAIDEN NAME

ELIZABETH ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

YES

W.W. II, NAVY

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MRS. BERTHA BERNSTEIN, 3900 N. CHARLES ST.

16. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Coronary thrombosis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 hr.

(B)

ASTHMA DUE TO, OR AS A CONSEQUENCE OF:

5 years

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Israel Zinberg

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

ISRAEL ZINBERG

23D. ADDRESS

4000 W. NORTHERN PKWY.

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE 6-29-1972

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

15 total

BURIAL

OHEB SHALOM MEMORIAL PARK

REISTERSTOWN, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

JUL 3 1972

25B. NAME OF REGISTRAR

Adrienne Winston

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

ADDRESS

7-7-1972 - Correction form from Funeral Director - Sol Levinson.

HRS

BALTIMORE, MARYLAND

BELT ROAD

REVEREND

WILLIAM

MR. JIMMY BERNSTEIN, 1000 N. CHARLES ST.

W. W. XI, N.Y.

low passed

~~RECEIVED~~

SOL LEVINSON & SONS, 1000 N. CHARLES ST., BALTIMORE, MD.

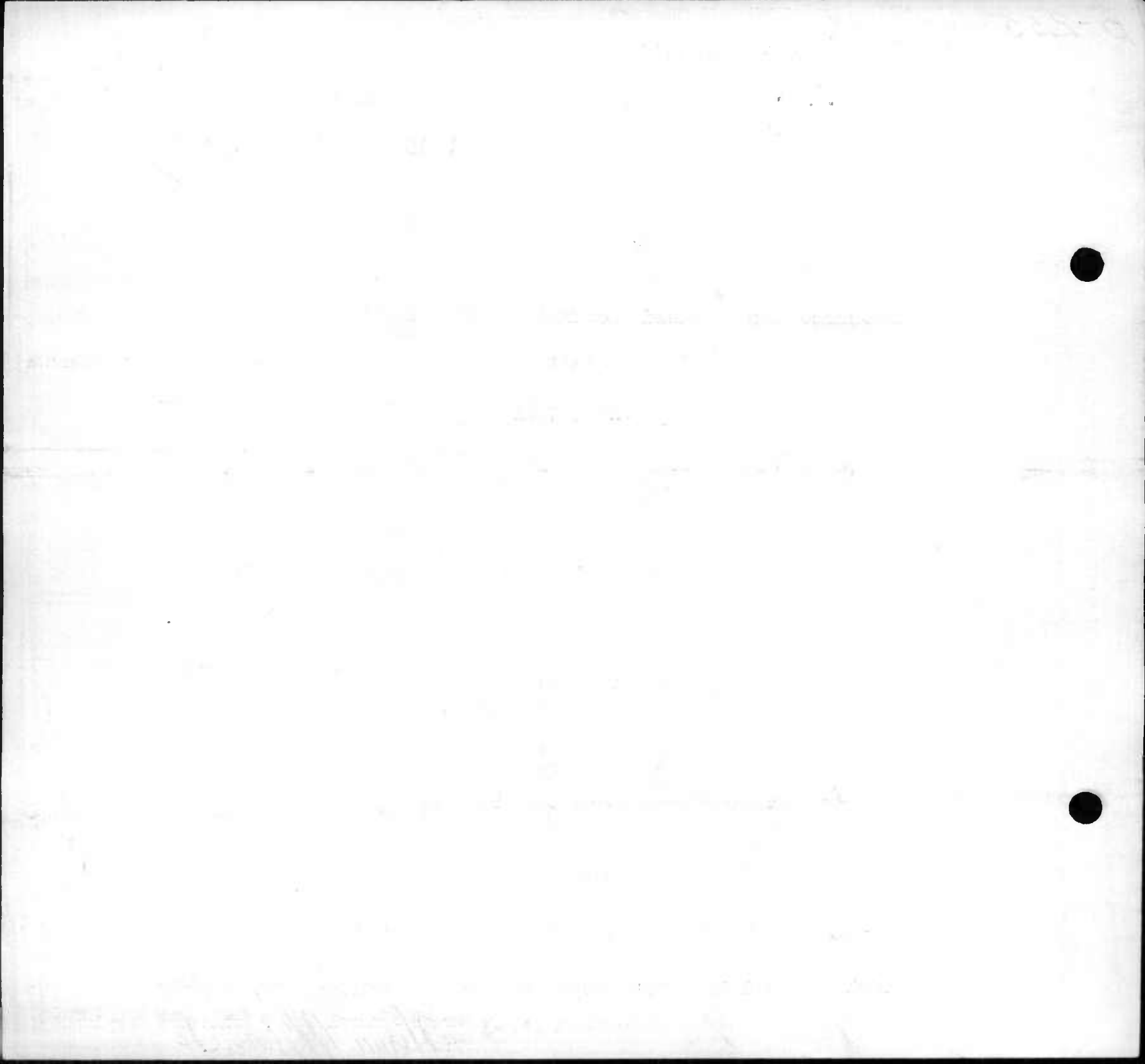
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06160	
BIRTH NO. 72 06160				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Jeffein, Rosa L.</u>		2. DATE AND HOUR OF DEATH <u>6-26-72</u> <u>6:15 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u> <u>42</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2730</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3301 Clarks Ln</u> <u>21215</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-20-1898</u>	9. AGE (in years last birthday) <u>73</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ALBERT LEVY</u>			
14. MOTHER'S MAIDEN NAME <u>JOHANNA BENESCH</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>218-32-3715B</u>		17. INFORMANT <u>MR. RALPH JEFFEIN, 3601 CLARKS LANE, APT. 308</u>			
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ASCVD</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>MENINGIOMA (SURGICALLY REMOVED)</u>					
19A. DATE OF OPERATION <u>6-22-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-22-72</u> to <u>6-26-72</u> that (I) (we) last saw the deceased alive on <u>6-26-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Peter Orosz</u>		23B. DATE SIGNED <u>6-26-72</u>		23C. PHYSICIAN'S NAME (Type) <u>PETER OROSZ MD</u>	
23D. ADDRESS <u>3 HUNTING RD APT 5</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/28/72</u>		24C. NAME of CEMETERY or CREMATORY <u>HEBREW FRIENDSHIP</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1972</u>			
25A. NAME OF REGISTRAR <u>Sidney Levinson</u>		25B. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPT. BALTIMORE CITY HEALTH DEPARTMENT											
72 06161 (John E Bachman) CERTIFICATE OF DEATH											
REG. NO. 100435											
BIRTH NO. 72 06161											
1. NAME OF DECEASED (Type or Print) JOHN E. BACHMAN						2. DATE AND HOUR OF DEATH JUNE 29, AM 2:40 P. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL, BALTO, MD, 21215						A. STATE B. COUNTY 1410 WELDON PL. #11 (MD)					
						C. CITY OR TOWN BALTO.			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
						E. STREET AND NUMBER 1410 WARDON PL. #11 1348					
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/21/02		9. AGE (In years last birthday) 70		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man				10B. KIND OF BUSINESS OR INDUSTRY Sinai Hospital				11. BIRTHPLACE (State or foreign country) HAWAII		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME N/A Unknown						14. MOTHER'S MAIDEN NAME N/A unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218 09 7221		17. INFORMANT ADDRESS PATIENT'S MEDICAL CHART					
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CARCINOMATOSIS											
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO-RESPIRATORY ARREST											
(B) DUE TO, OR AS A CONSEQUENCE OF: EMACIATION, DEHYDRATION											
(C)											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 2/31/72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL PAIN				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/27/72 to 6/29/72 that (I) (we) last saw the deceased alive on 6/29/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE [Signature]						23B. DATE SIGNED 6/29/72			23C. PHYSICIAN'S NAME (Type) CAROL T. PIZON, MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial						24B. DATE 3 Jul 72		24C. NAME of CEMETERY or CREMATORY May's Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972				25B. NAME OF REGISTRAR [Signature]				25C. FUNERAL DIRECTOR [Signature] ADDRESS [Signature] Baltimore Maryland			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

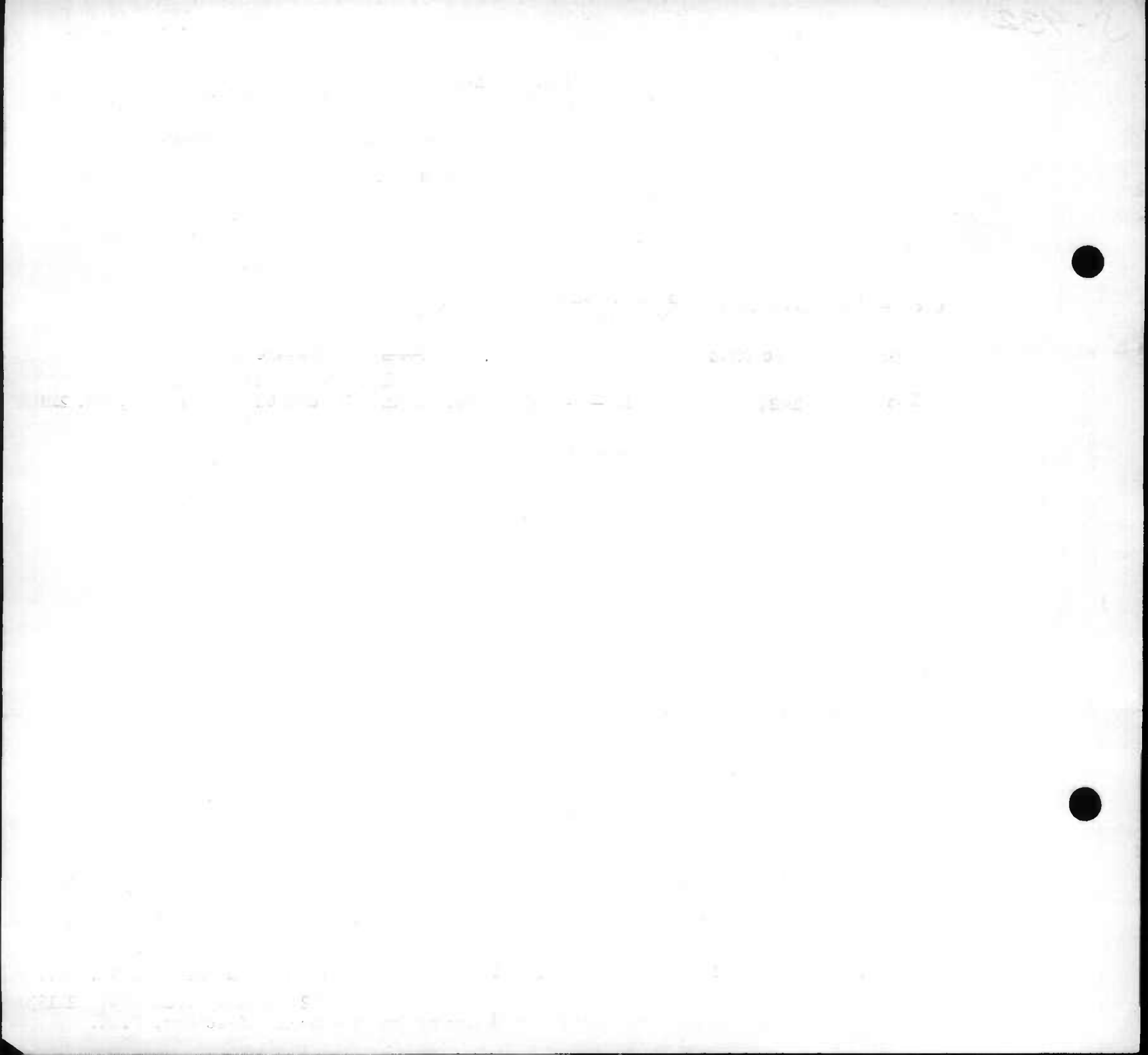
72 06162

CERTIFICATE OF DEATH

REG. NO.

72 06162

BIRTH NO. 72 06162		2. DATE AND HOUR OF DEATH JUNE 29, 1972 10 ⁴⁵ P.M.	
1. NAME OF DECEASED (Type or Print) SCHULTZ, CLYDE Paul		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. SEX M. 6. RACE W. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10/27/04		9. AGE (In years last birthday) 67	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook - Food Attendant		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Schultz	
14. MOTHER'S MAIDEN NAME Emma (Tressler)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1924	
16. SOCIAL SECURITY NO. 217-03-8743		17. INFORMANT 1848 Reisterstown Road ADDRESS Mrs. Elizabeth Schultz Pikesville, Md. 21208	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF THE BLADDER		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 26 19 72 to JUNE 29 19 72 that (I) (we) last saw the deceased alive on JUNE 29 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Raul Pinfo M.D.		23B. DATE SIGNED JUNE 29/72	
23C. PHYSICIAN'S NAME (Type) RAUL PINO		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/1972	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION Pikesville, Maryland Balto. Co., Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Sidney W. Horton	
25C. FUNERAL DIRECTOR Loring Byers Funeral Directors, P. A.		25D. ADDRESS 8728 Liberty Road 21133	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEMO BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06163
BIRTH NO. 72 06163		CERTIFICATE OF DEATH		
1. NAME OF DECEASED Type or Print Hurdle Edward A		2. DATE AND HOUR OF DEATH 6-28-72 4 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2739		
FULL NAME OF HOSPITAL OR INSTITUTION CERTIFICATE AMENDED Mercy 7-17-72 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1444 Winston Ave		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		8. DATE OF BIRTH July 1, 1911 9. AGE (In years lost birthday) 60 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harry Hurdle		14. MOTHER'S MAIDEN NAME Dora M Green		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-8484 17. INFORMANT Mrs Regina A Hurdle ADDRESS Same		
18. 185X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CA of prostate ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pneumonia		
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21C. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21D. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from June 28 19 72 to June 28 19 72 and that (I) (we) last saw the deceased alive on June 28 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Josecito S. Alvarez Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6/28/72
23C. PHYSICIAN'S NAME (Type) Josecito S Alvarez		23D. ADDRESS Mercy Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/72		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. July 3 1972 25B. NAME OF REGISTRAR Audrey Johnston 25C. FUNERAL DIRECTOR Leonard J Ruck Inc. ADDRESS Baltimore, Md		

7-17-1972 - Correction form from Funeral Director - Leonard J. Ruck, Inc.

5309 Harford Road

Balto., Md. (Michael J. Ruck)

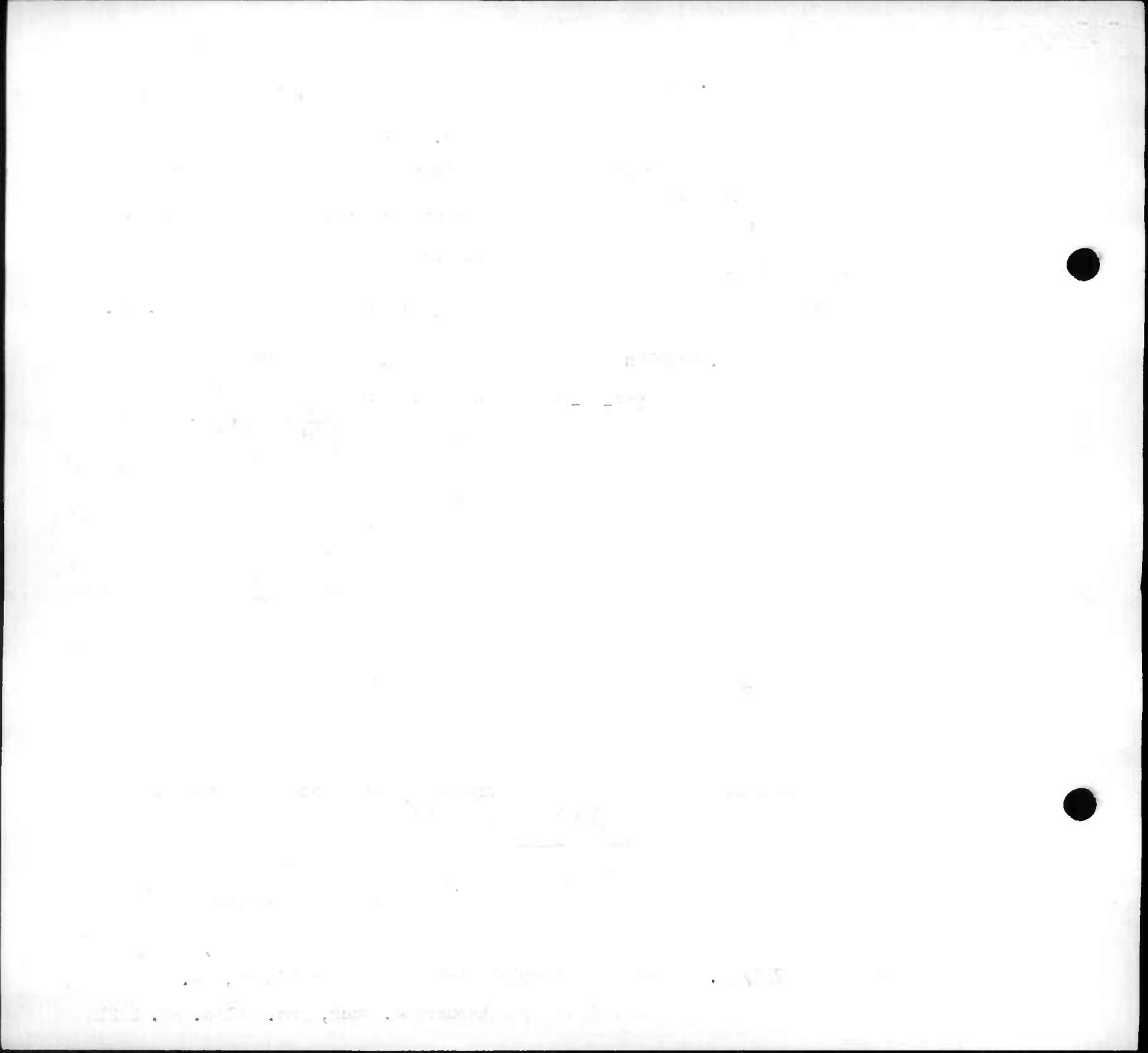
HRS

60-10-05
B-245

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

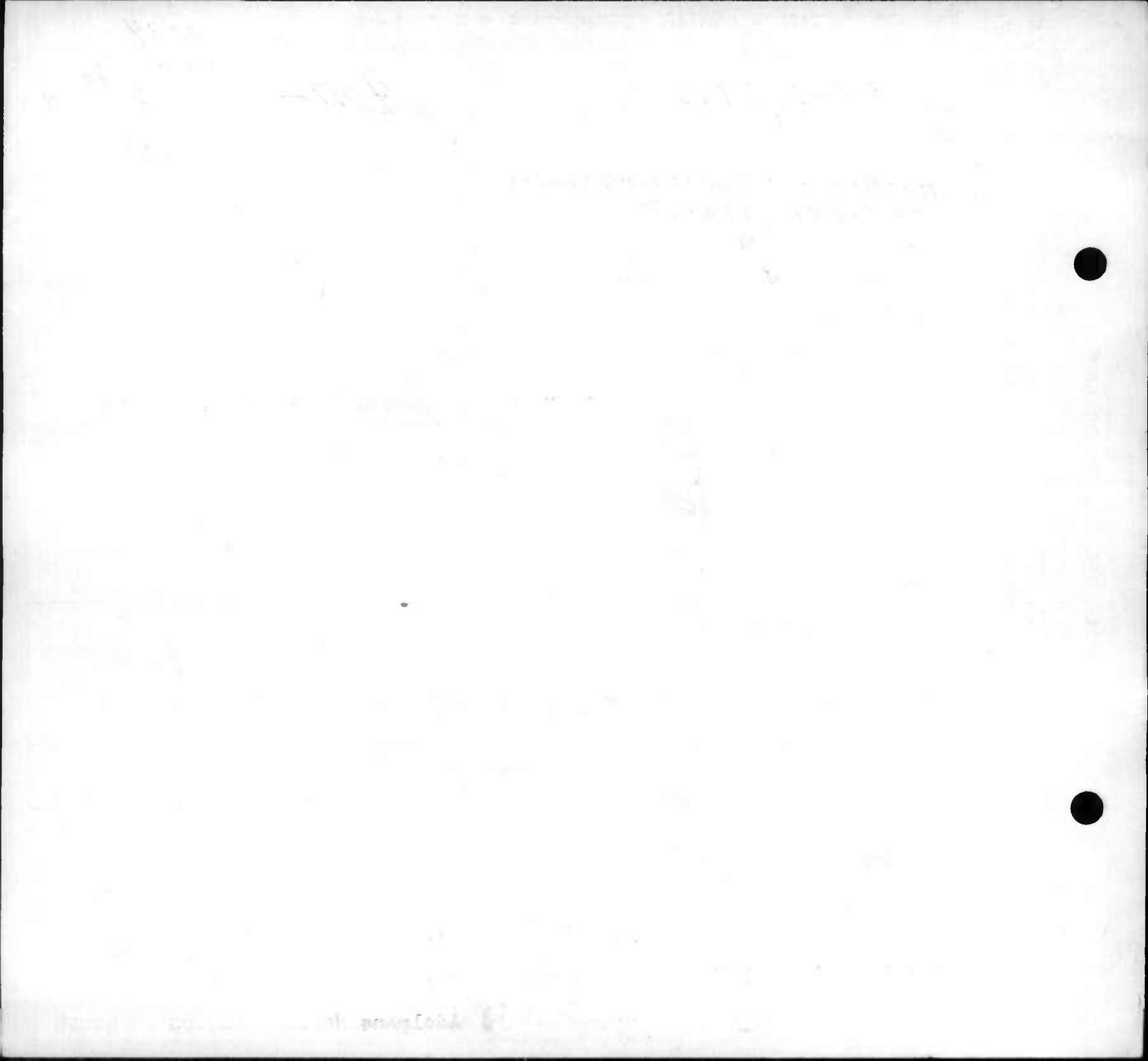
STATE OF MARYLAND - DHMH		BALTIMORE CITY HEALTH DEPARTMENT	
72 06164		72 06164	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Basil E. Buckland		June 28, 1972 8:50 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
31 Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland 2734	
		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
		Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER	
		5439 Belle Vista Avenue 21206	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-10-16
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
Mechanic			56
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
West Virginia		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Joseph M. Buckland		Mary Peterson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		235-16-1111	
17. INFORMANT		ADDRESS	
BCH Records:		4940 Eastern Avenue Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		BRONCHOPNEUMONIA CANCER OF LUNG.	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) METASTASIS.	
		(C) PARALYSIS.	
II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		6 M.	
19A. DATE OF OPERATION		6 M.	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		3 M.	
20A. AUTOPSY? (Yes or No)			
Yes			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month (Day) (Year) (Hour) (Approx.))	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 21 1972 to JUNE 28 1972 that (I) (we) last saw the deceased alive on JUNE 28 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Surat Sinasa, M.D.		June 28, 72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
SURAT SINASA		4940 Eastern Avenue BALTIMORE CITY HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8/1/72.	Moreland Memorial Park	Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JUL 3 1972	Andrew H. Houston	Leonard J. Ruck, Inc.	Balto. Md. 21214



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					REG. NO. <u>1234</u> <u>72 06165</u>				
BIRTH NO. <u>72 06165</u>					1. NAME OF DECEASED (Type or Print) <u>LAWSON, OTIS</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>HARBOR VIEW NURSING CENTER</u> <u>1213 LIGHT STREET</u>					2. DATE AND HOUR OF DEATH <u>4/28/72</u> <u>3</u> <u>10</u> <u>P</u> M.				
4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1608</u>					C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER <u>1306 Wildwood Pkwy</u>									
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1898</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Old Age</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lynchburg S C</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>		
13. FATHER'S NAME <u>John Law</u>					14. MOTHER'S MAIDEN NAME <u>Mary</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>259-30-8713</u>		17. INFORMANT <u>Mrs Nadine Roberson</u>			ADDRESS <u>Sam e</u>	
18. <u>4/28/72</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>A.S.C.V. Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Relat. leg amputation</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>4/4</u> 19 <u>72</u> to <u>6/28</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6/10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Joseph S. Blum</u>					23B. DATE SIGNED <u>6/29/72</u>			23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM MD</u>	
23D. ADDRESS <u>1115th CARVER ST</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>7/1/72</u>		24C. NAME of CEMETERY or CREMATORY <u>MT Auburn Cemetry</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1972</u>			25B. NAME OF REGISTRAR <u>Adolphus Halsteas</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halsteas</u>			ADDRESS <u>12066 W North</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPARTMENT OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06166	
BIRTH NO. 72 06166				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) WILLIAM J. BERTLING		2. DATE AND HOUR OF DEATH 6/28/72 2:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2641		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-22-09		9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED T.V. & RADIO REPAIRS	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ?	
14. MOTHER'S MAIDEN NAME BARBARA EREK		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-18-9173	
17. INFORMANT MRS. Edith Bertling		ADDRESS (SAME)		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) UREMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA of the BLADDER II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ANEMIA	
19A. DATE OF OPERATION 6/17/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/17/72 to 6/28/72 , that (I) (we) last saw the deceased alive on 6/28/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ramon del Busto				23B. DATE SIGNED 6/28/72	
23C. PHYSICIAN'S NAME (Type) RAMON del Busto		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/72		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972			
25B. NAME OF REGISTRAR Andrew Winston		25C. FUNERAL DIRECTOR Leona rd J. Ruck, Inc. Balto. Md. 21214			

C-562

STATE OF MARYLAND-DEMH
BALTIMORE CITY HEALTH DEPARTMENT

72 06187

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06187

REG. NO.

CERTIFICATE AMENDED 2-14-73

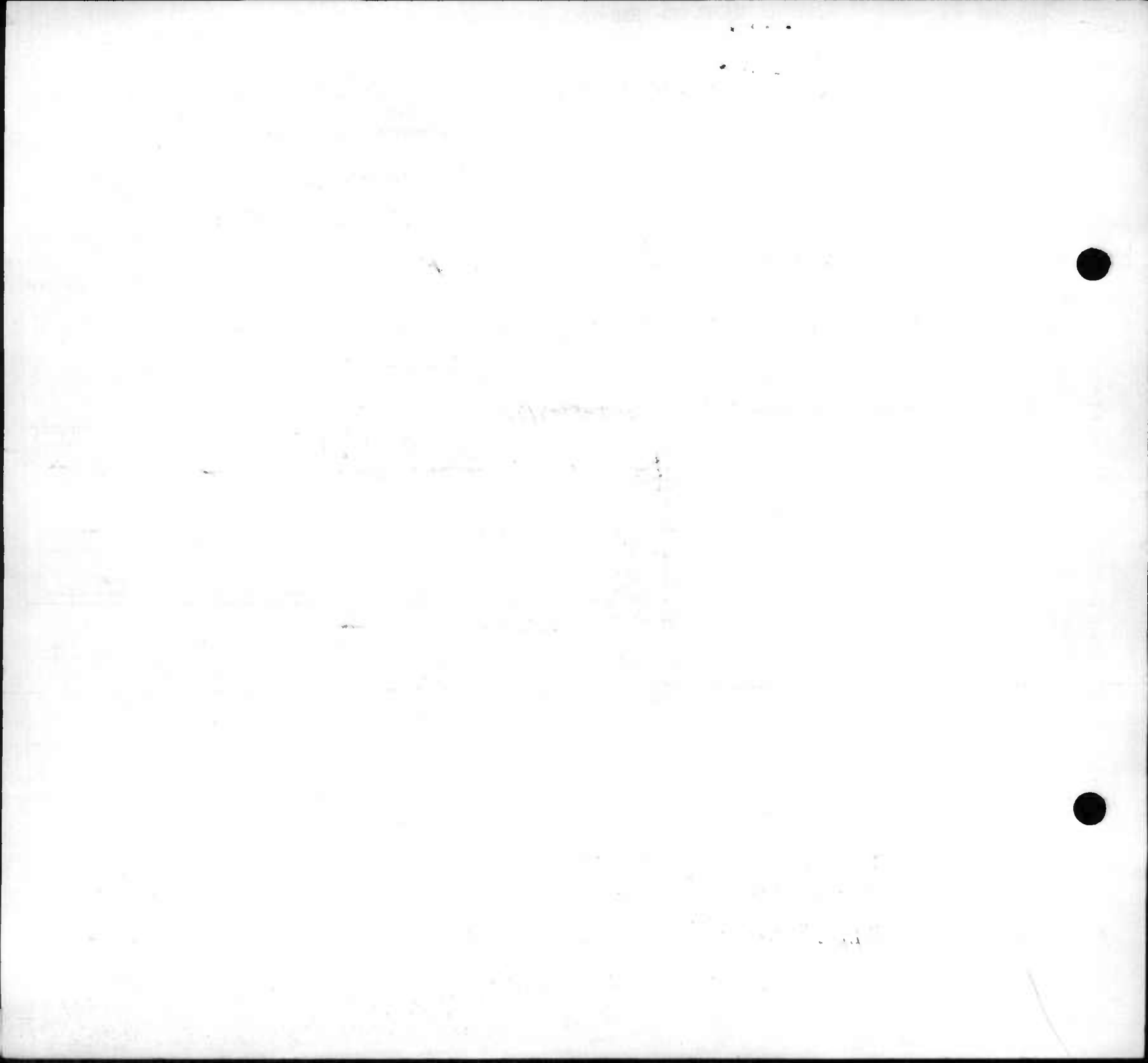
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Edward WALTER E. CONNERS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> June 30, 1972		Month Day Year Hour June 30, 1972 12:27 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp.		3. DATE PRONOUNCED DEAD June 30, 1972		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2301		6. SEX Male 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Sept. 28, 1920		10. AGE (In years lost birthday) 51		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel A. Connors		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Attendant		14B. KIND OF BUSINESS OR INDUSTRY Gasoline		15. MOTHER'S MAIDEN NAME Ethel M. White	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) yes WW 2		17. SOCIAL SECURITY NO. unknown		18. INFORMANT Evelyn Marshall		ADDRESS 129 E. Randall Street	
19. E 9165 X		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Tavern		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1132 S. Hanover Street		2301	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 6-30-72 12:17 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during attempt at robbery by unknown assailant			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 30, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/72		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Audrey Whitford		25C. FUNERAL DIRECTOR Mc Cully Funeral Homes		ADDRESS 130 E. Font Avenue	

2-14-1973 - Letter from the Office of the Chief Medical Examiner, Marvin S. Platt, M.D.
Assistant Medical Examiner hs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEATH BALTIMORE CITY HEALTH DEPARTMENT									
72 06168					CERTIFICATE OF DEATH				
BIRTH NO.					REG. NO. 72 06168				
1. NAME OF DECEASED (Type or Print) HAROLD O. GALENTINE JR.					2. DATE AND HOUR OF DEATH 6/30/72 4:20 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE BALTIMORE MD. B. COUNTY 1803				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL					C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER 1018 W Pratt St.				
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/50	9. AGE (In years last birthday) 21	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC			10B. KIND OF BUSINESS OR INDUSTRY TRUCK BODY CO.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME HAROLD O. GALENTINE SR.					14. MOTHER'S MAIDEN NAME CECELIA BENTON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 612-569193		17. INFORMANT FATHER & CHART				
18. 30491					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					NARCOTIC ADDICTION (A) IMMEDIATE CAUSE ANGIE BRAIN DAMAGE DUE TO, OR AS A CONSEQUENCE OF:				
					(B) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF:				
					(C) HEROIN USE				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 7/1		19B. CONDITION WHEN OPERATION WAS PERFORMED		19C. WHICH OPERATION		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/25 19 72 to 6/30 19 72 that (I) (we) last saw the deceased alive on 6/30 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Paul D. Light M.D.					23B. DATE SIGNED 6/30/72		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		
23C. PHYSICIAN'S NAME (Type) PAUL D. LIGHT M.D.					23D. ADDRESS UNIVERSITY HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/72		24C. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972			25B. NAME OF REGISTRAR Lidney W. Weston			25C. FUNERAL DIRECTOR John J. Cowan & Son Inc.			
						ADDRESS 901 Hollins St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEMO BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00169	
BIRTH NO. 72 00169				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BRACKLEY, ELIZABETH M.			2. DATE AND HOUR OF DEATH JULY 1, 1972 5:30A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NEW YORK B. COUNTY ALBANY CO. C. CITY OR TOWN WATERVLIET D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 639 THIRD AVE.		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05 23 90	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RECEPTIONIST		10B. KIND OF BUSINESS OR INDUSTRY DR'S OFFICE	11. BIRTHPLACE (State or foreign country) NEW YORK, N. Y.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME PATRICK HOGAN			14. MOTHER'S MAIDEN NAME ELIZABETH DILLON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 062121104	17. INFORMANT BALTIMORE, MD. 21229 ADDRESS ST. AGNES'S RECORDS-CATON & WILKENS AVE		
18. 154.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Cancer of Rectum with metastases ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 10 1972 to JULY 1, 1972 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 1 1972 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <i>M. Yousuf Siddiqui</i>			23B. DATE SIGNED 7/1/1972		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) YOUSEF SIDDIQUI			23D. ADDRESS ST AGNES HOSPITAL-BALTIMORE, MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-5-72	24C. NAME OF CEMETERY or CREMATORY ST. AGNES		24D. LOCATION (City, town, or county) (State) COHoes N.Y.
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR <i>Audrey Johnston</i>		25C. FUNERAL DIRECTOR THOMAS SHARPA 220 E. MEDWICK GARTH	

2:30

JULY 1, 1972

SARLEY, ELIZABETH W.

ST. ROSE'S HOSPITAL
2400 S. WILSON AVENUE
CHICAGO, ILLINOIS 60608

JULY 23 1972

KX

TRIPLE CHOCOLATE

ST. ROSE'S HOSPITAL

CHICAGO, ILLINOIS

ELIZABETH W. SARLEY

ST. ROSE'S HOSPITAL

CHICAGO, ILLINOIS

ST. ROSE'S HOSPITAL - CHICAGO, ILLINOIS

NO

NO

JULY 1, 1972

JULY 1, 1972

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ST. ROSE'S HOSPITAL - CHICAGO, ILLINOIS

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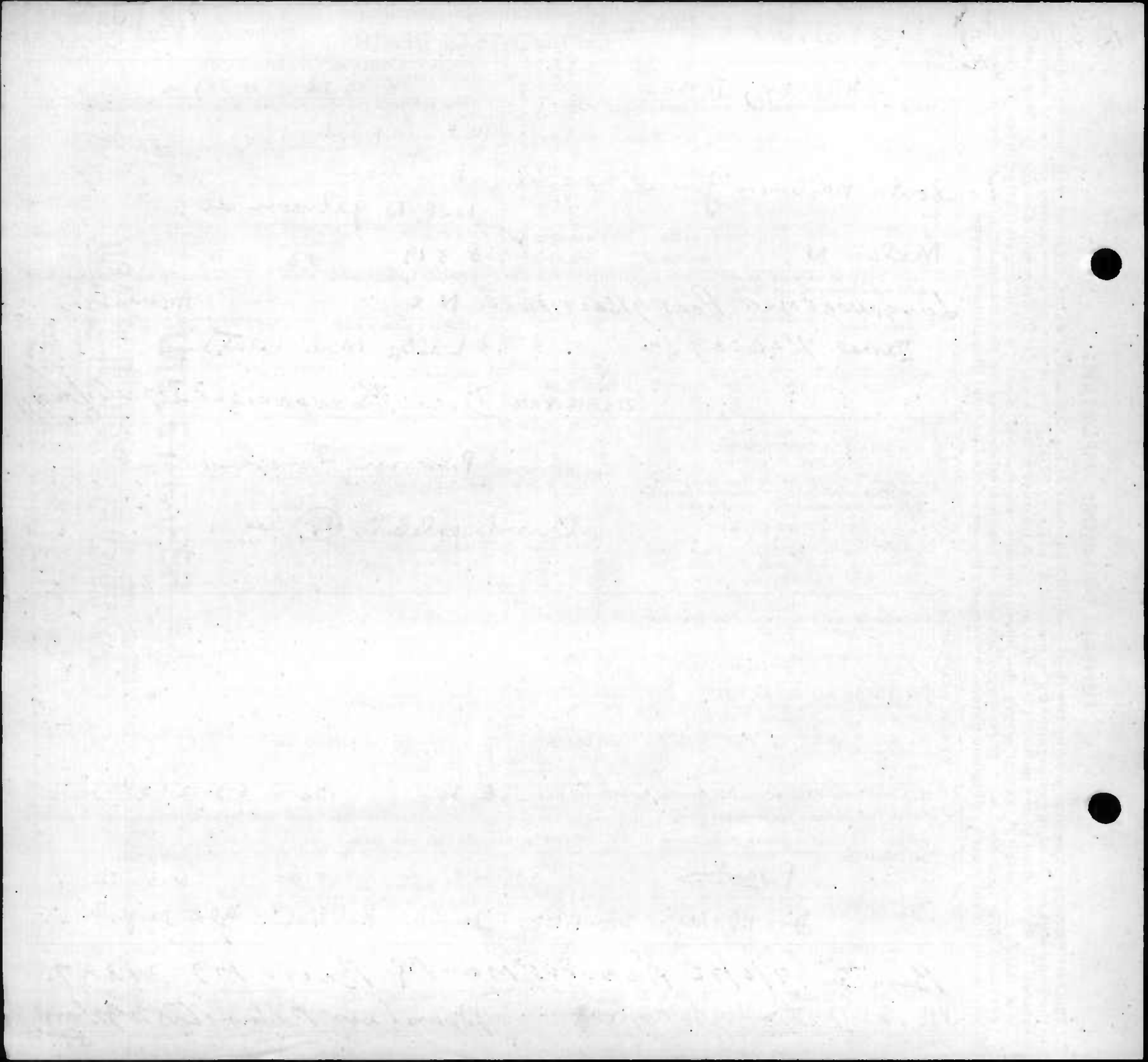
ST. ROSE'S HOSPITAL

NO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPT. OF HEALTH		BALTIMORE CITY HEALTH DEPARTMENT	
72 06170		72 06170	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) HARLEY, JAMES		2. DATE AND HOUR OF DEATH 6.30.72 11:55 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5.3.19 9. AGE (In years last birthday) 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHOREMAN PORT & BALTIMORE		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME James Harley Sr		12. CITIZEN OF WHAT COUNTRY? America	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-128916	
17. INFORMANT DORIS BASKIN		ADDRESS 37 N. Gilmore St.	
18. 451.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Thrombophlebitis (pt) leg.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6.30 19 72 to 6.30.72 (5:50) 19 72 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE P. Sawhney		23B. DATE SIGNED 6.30.72	
23C. PHYSICIAN'S NAME (Type) Dr. PAVANJIT SAWHNEY		23D. ADDRESS South Baltimore Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/72	
24C. NAME OF CEMETERY OR CREMATORY Arbours Mount		24D. LOCATION (City, town, or county) (State) Baltimore MD 21227	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Andrew Johnston	
25C. FUNERAL DIRECTOR James P. Hays		ADDRESS 635 N. Gilmore St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DEPT. OF HEALTH				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06171	
BIRTH NO. 21 06171		1. NAME OF DECEASED (Type or Print) NATHANIEL BAGBY		2. DATE AND HOUR OF DEATH JUN 29-1972 8:00 P M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1030 BRANTLEY AVE				A. STATE MD B. COUNTY 1601		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-22-1913 68		9. AGE (In years last birthday) 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION LABOR				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MIDDLESEX GVE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE BAGBY				14. MOTHER'S MAIDEN NAME CATHERINE HOLMES					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 1				16. SOCIAL SECURITY NO. 220-03-3440AA		17. INFORMANT JUDITH BAGBY 1030 BRANTLEY AVE			
18. 191X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH METASTATIC CARCINOMA, INVOLVING Brain, lung, kidneys				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Donald H. Kulp, M.D. DEGREE				23B. DATE SIGNED 7/1/72		23C. PHYSICIAN'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/5/72		24C. NAME OF CEMETERY OR CREMATORY MARIAN		24D. LOCATION (City, town, or county) (State) Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972				25B. NAME OF REGISTRAR Sidney Whitcomb		25C. FUNERAL DIRECTOR Markham & Hugo 6320 Gilman St			

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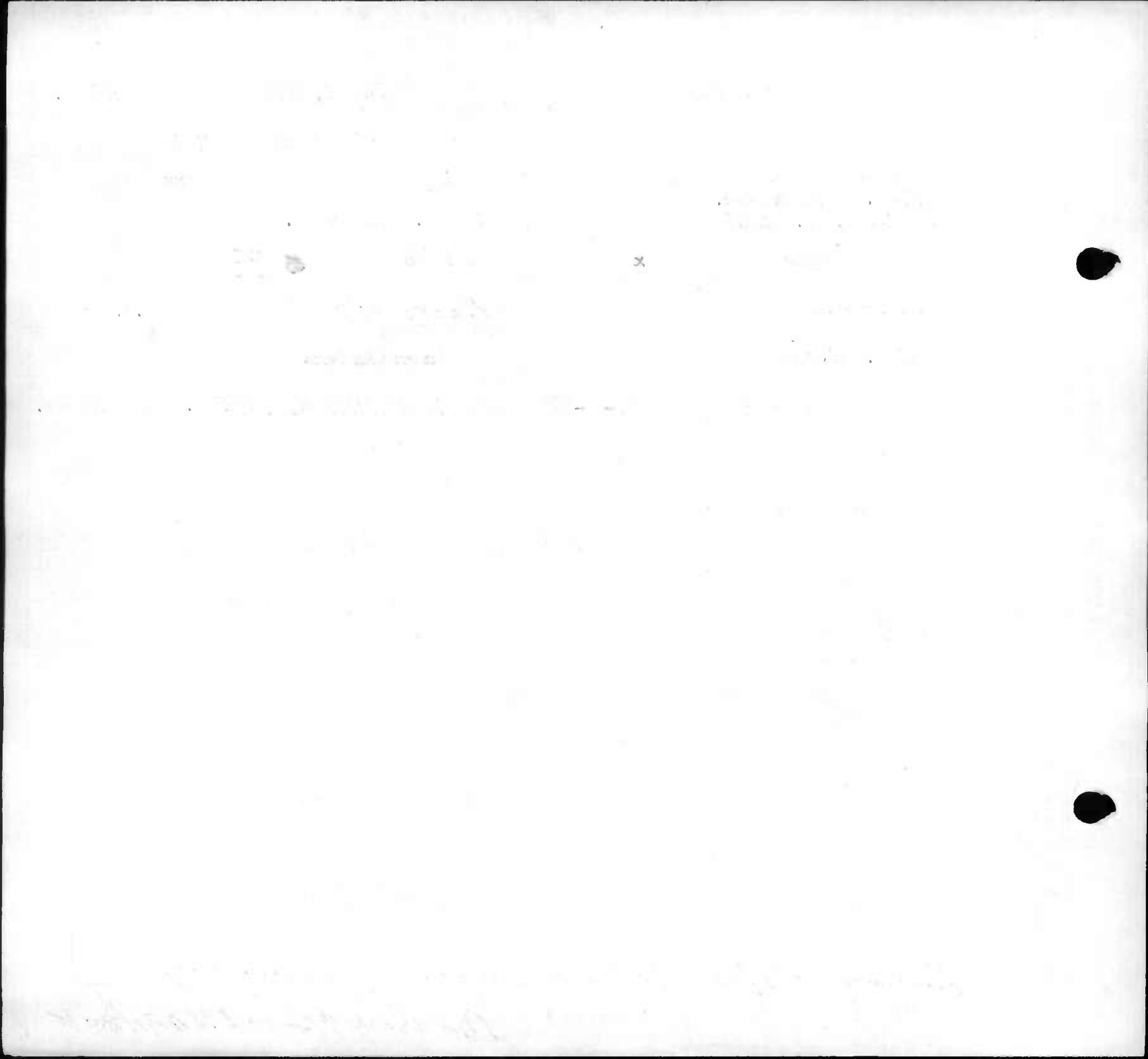
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06172 STATE OF MARYLAND - DEPARTMENT OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06172	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Johnson, Andrew</u>		2. DATE AND HOUR OF DEATH <u>July 1, 1972</u> <u>6:15 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> <u>21223</u> <u>2001</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>HOUSE IN THE PINES BELVEDERE</u> <u>2525 W. Belvedere Ave.</u> <u>Baltimore, Md. 21215</u>		C. CITY OR TOWN <u>City</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1930 W. Saratoga St.</u>			
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/88</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTER</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>83</u>
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John H. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Laura Chambers</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Army</u> <u>1942-45</u>		16. SOCIAL SECURITY NO. <u>217-07-8887</u>	
17. INFORMANT		ADDRESS	
<u>HOUSE IN THE PINES BELV. 2525 W. Belvedere Ave.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>CVA -</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Advanced ASCVD</u> <u>years.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-1-72</u> to <u>7-1-72</u> that (I) (we) last saw the deceased alive on <u>7-1-72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>William L. Cohen</u> MD DEGREE		23B. DATE SIGNED <u>7-2-72</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>3501 St. Paul St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7/5/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>MT ZION CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>Major St. MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1972</u>		25B. NAME OF REGISTRAR <u>Arvey W. Horton</u>	
25C. FUNERAL DIRECTOR <u>David R. P. Long</u>		ADDRESS <u>2301 9th St. NW</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 72 06173

REG. NO.

1. NAME OF DECEASED (Type or Print) LORNA HAMMOND		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour June 28, 1972	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 28, 1972 6:40 P.M.	
6. SEX Female	7. RACE Negro	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY HOWARD	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Columbia		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 10-9-67	10. AGE (In years lost birthday) 4	E. STREET AND NUMBER 10667 Green Mountain Circle	
11. BIRTHPLACE (State or foreign country) Dover, Delaware	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Rev. Clayton Hammond	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	14B. KIND OF BUSINESS OR INDUSTRY na	15. MOTHER'S MAIDEN NAME Anna K. Banks	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	17. SOCIAL SECURITY NO. none	18. INFORMANT ADDRESS 10667 Green Mountain Circle, Columbia, Md. Rev. Clayton & Mrs. Anna B. Hammond 21043	
19. CAUSE OF DEATH E814.17 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME OF INJURY (APPROX.) 6-28-72 5:34 P.m.		22C. WHERE DID INJURY OCCUR? Intersection of Green Mountain Circle & Rain Dream Hill Road, Columbia, Md.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Child struck by driver-less auto when brakes broke loose from parking position	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 29, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-2-72	24C. NAME OF CEMETERY OR CREMATORY Christ Esp. Cemetery	24D. LOCATION (City, town, or county) (State) Oakland Mills Village Columbia, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972	25B. NAME OF REGISTRAR Ardrey Houston	25C. FUNERAL DIRECTOR ADDRESS 1735 Harford Ave. 21213 Marshall W. Jones, Jr.	

10-9-67

10067

Power, Delaware

U. S. A.

Rev. Clayton Hammond

born

in

Anna T. Taylor

no

none

10067 Green Mountain School, Colorado
Rev. Clayton & Mrs. Anna T. Hammond

Rev. Clayton Hammond

MAIL ROOM

Charles E. Hammond, N.Y.

7-5-72

Chief Exp. Secretary

Oakland Mills Village

Columbia, Maryland

1735 Westford Ave. 21217

Marshall W. Jones, Jr.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES RONNIE HILTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 2, 1972 5:50 A.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Roanoke, Virginia B. COUNTY 43	
9. DATE OF BIRTH 8-6-46		10. AGE (In years last birthday) 25 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Roanoke, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Hilton		14. MOTHER'S MAIDEN NAME Mary B. Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. CAUSE OF DEATH Multiple Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTCEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) On 695 at Cromwell Bridge Rd. Balto. beltway			
22D. TIME OF INJURY (APPROX.) 7-2-72 12:15 A.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Driver struck auto and then utility pole			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) DATE SIGNED 7/2/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Transit-burial		24B. DATE 7-6-1972	
24C. NAME of CEMETERY or CREMATORY Wms. Memorial Pk.		24D. LOCATION (City, town, or county) (State) Roanoke, Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Adrian W. Horton	
25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213 Marshall W. Jones, Jr.			

Roanoke, Virginia

Roanoke

Charles W. Wilson

U.S.A.

Roanoke, Virginia

Mary E. Moore

Track Driver

Laborer

1111 S. Main St., Roanoke, Virginia
Mrs. Mary E. Moore Wilson

no

Roanoke, Virginia

Roanoke, Virginia

John. Memorial Bldg.

7-6-1912

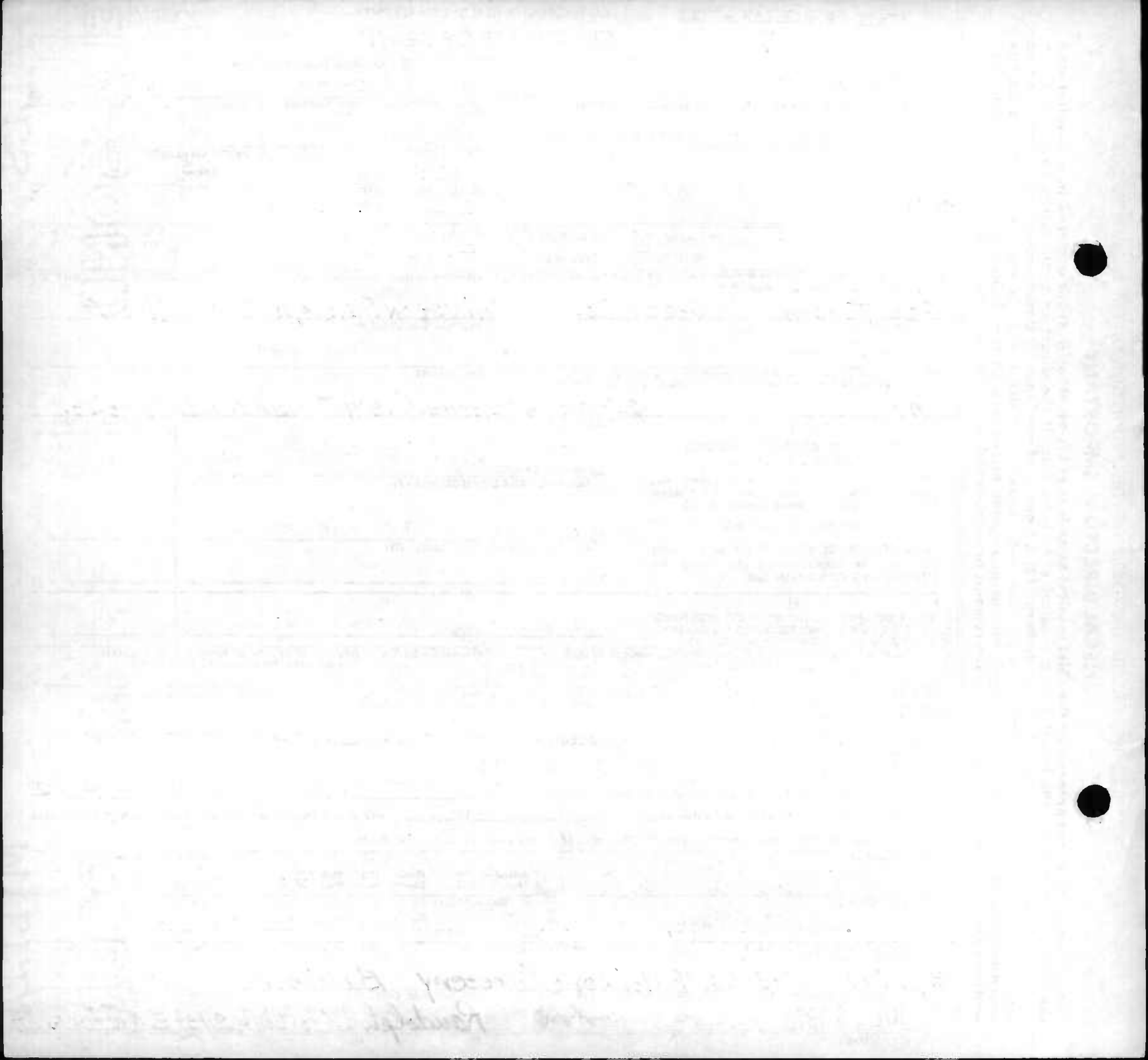
1733 S. Main St., Roanoke, Va.

Marshall V. Jones, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPT. OF HEALTH		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06175	
BIRTH NO. 72 06175		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>LEROY TILLER</u>		2. DATE AND HOUR OF DEATH <u>6-29-72</u> <u>1:53 PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>33 JOHNS HOPKINS HOSP.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>802</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSP.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4-18-09</u>		9. AGE (In years last birthday) <u>63</u>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas Tender</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>WINSTON-SALEM, N. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Berry Tiller</u>		14. MOTHER'S MAIDEN NAME <u>Maddie Lyde</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-0167</u>		17. INFORMANT <u>CATHERINE W. Tiller 1611 N. Port St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>148.91</u> <u>PNEUMOTHORAX, pulmonary edema, poss. MI; CARDIAC ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>23 mo's</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>UNDERGOING RECONSTRUCTIVE SURG.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA of HYPOPHARYNX</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u></u>	
(C) <u></u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>UNDERGOING RECONSTRUCTIVE SURG.</u>					
19A. DATE OF OPERATION <u>6-28-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RECONSTRUCTION S/P LARYNGO-EPHARYNGITIS</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u></u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u></u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u></u>		21C. WHERE DID INJURY OCCUR? <u></u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u></u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u></u>	
22. I certify that (I) (this hospital) attended the deceased from <u>8</u> 19 <u>70</u> to <u>6-29</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6-29</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Michael West, M.D.</u>		23B. DATE SIGNED <u>6-29-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>J. Michael West, M.D.</u>		23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-3-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1972</u>		25B. NAME OF REGISTRAR <u>Randolph J. Collick</u>		25C. FUNERAL DIRECTOR ADDRESS <u>2431 E. Oliver St.</u>	



1

M-200

STATE OF MARYLAND-DEPT

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06176

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JAMES MC COY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour June 29, 1972 8:10 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1972 8:10 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 130.3	
9. DATE OF BIRTH April 12, 1912		10. AGE (In years last birthday) 60	
11. BIRTHPLACE (State or foreign country) Murrell Inlet, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel McCoy		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR WORKER	
15. MOTHER'S MAIDEN NAME Lula D. McCoy		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Willie Gerald	
19. E-812.10 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Fracture of cervical spine with spinal cord injury (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. DATE OF OPERATION 2	
21. AUTOPSY? (Yes or No) Yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
23. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		24. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2400 blk S. Hanover Street 230.3	
25. TIME OF INJURY (APPROX.) 6-13-72 8:15 P. M.		26. HOW DID INJURY OCCUR? Driver in auto-auto collision	
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
29. ACTUAL SIGNATURE Charles S. Springate, M.D.		30. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
31. EXAMINER'S NAME (Type) Charles S. Springate, M.D.		32. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
33. DATE REC'D BY HEALTH DEPT. JUL 1 1972		34. NAME OF REGISTRAR Walter D. Dwyer	
35. DATE OF BURIAL CREMATION, REMOVAL (Specify) Burial		36. DATE 7-6-72	
37. NAME OF CEMETERY or CREMATORY Gordon Chapel Cemetery		38. LOCATION (City, town, or county) (State) Murrell Inlet, South Carolina	
39. FUNERAL DIRECTOR Walter D. Dwyer		40. ADDRESS 1701 Laurens St.	

7-14-1972 - Completion of cause of death on a pending medical examiner death certificate.

Charles S. Springate, M.D.

HS

2

x

copy

initial

copy

copy

copy

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CELIE LUCAS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 1, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year July 1, 1972 Hour 5:42 P. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Ellem City	
9. DATE OF BIRTH 1-1-25		10. AGE (In years lost birthday) 47 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse Aide		14B. KIND OF BUSINESS OR INDUSTRY Wilson Hospital	
15. MOTHER'S MAIDEN NAME Hattie Sase		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Larse Lucas Ellem City Rt. 1 N.C	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/2/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-5-72	
24C. NAME OF CEMETERY or CREMATORY FAMILY CEMETERY		24D. LOCATION (City, town, or county) (State) ELM CITY, N. C.	
25A. DATE RECORDED WITH DEPT. OF HEALTH JUL 18 1972		25B. NAME OF REGISTRAR 7200003175	
25C. FUNERAL DIRECTOR MORTON & DYETT		ADDRESS 1701 Laurens Street, MD.	

DATE: 1/1/72

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

1/1/72

1/1/72

John F. [illegible]

North Carolina

Little Rock

William [illegible]

James [illegible]

Large [illegible] City [illegible]

Department of [illegible]
[illegible]

[illegible]
[illegible]

MAIL ROOM

204 [illegible]

[Handwritten signature]

EL CITY, N. C.

EL CITY, N. C.

7-8-72

BUFILE

OTON & [illegible]

7-8-72

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND, DISTRICT

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 06178

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

David H. Moore

2. DATE AND HOUR OF DEATH

7-1-72

1145 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CERTIFICATE AMENDED

Luthern Hospital 7md 7-25-72

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

md -

1509

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

3827 Clifton Ave

5. SEX

MALE

6. RACE

Black

7. MARRIED

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

3-6-1891

9. AGE (in years last birthday)

78

10. Under 1 Yr. Months

Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Plitt Co. N. Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John R. Moore

14. MOTHER'S MAIDEN NAME

Lucinda Moore

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

237-468744

17. INFORMANT

Lenora Moore - 3827 Clifton Ave.

ADDRESS

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Arrest.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ASCVD

(C)

Coronary heart disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1, 1972 to July 1, 1972 that (I) (we) last saw the deceased alive on July 1, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Narong Ruchira

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

July 2, 72.

23C. PHYSICIAN'S NAME (Type)

NARONG RUCHIRAPAD

DEGREE

23D. ADDRESS

1133 Penney Lane AK

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial 7-5-72

Arbutus Cemetery, Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 3 1972

Narong Ruchira

Moore & Dyett F.H. 201-5P

7-25-1972 - Correction form from Funeral Director.

HRS

Delayed Certificate of Birth Registration
County of Pitt, State of North Carolina
David Henry Moore - born March 6, 1894.

1

STATE OF MARYLAND-DEATH

BALTIMORE CITY HEALTH DEPARTMENT

72 06179

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) WILLIAM HARRIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour June 29, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1705 W. Lanvale Street		3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1972 1:00 P. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1603			
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. CITY OR TOWN Baltimore
10. AGE (In years, last birthday) 49		11. DATE OF BIRTH OCT 3, 1922	
12. CITIZEN OF U. S. A.		13. FATHER'S NAME SAMUEL HARRIS	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME BESSIE HARRIS	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT KATHERINE HARRIS		ADDRESS 1615 EDMONDSON AVE.	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Epilepsy		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 30, 1972 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-3-72	
24C. NAME OF CEMETERY or CREMATORY WESTERN STAR CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Lidney	
25C. FUNERAL DIRECTOR MORTON & DYETT F. H.		ADDRESS 1701 LAURENS ST.	

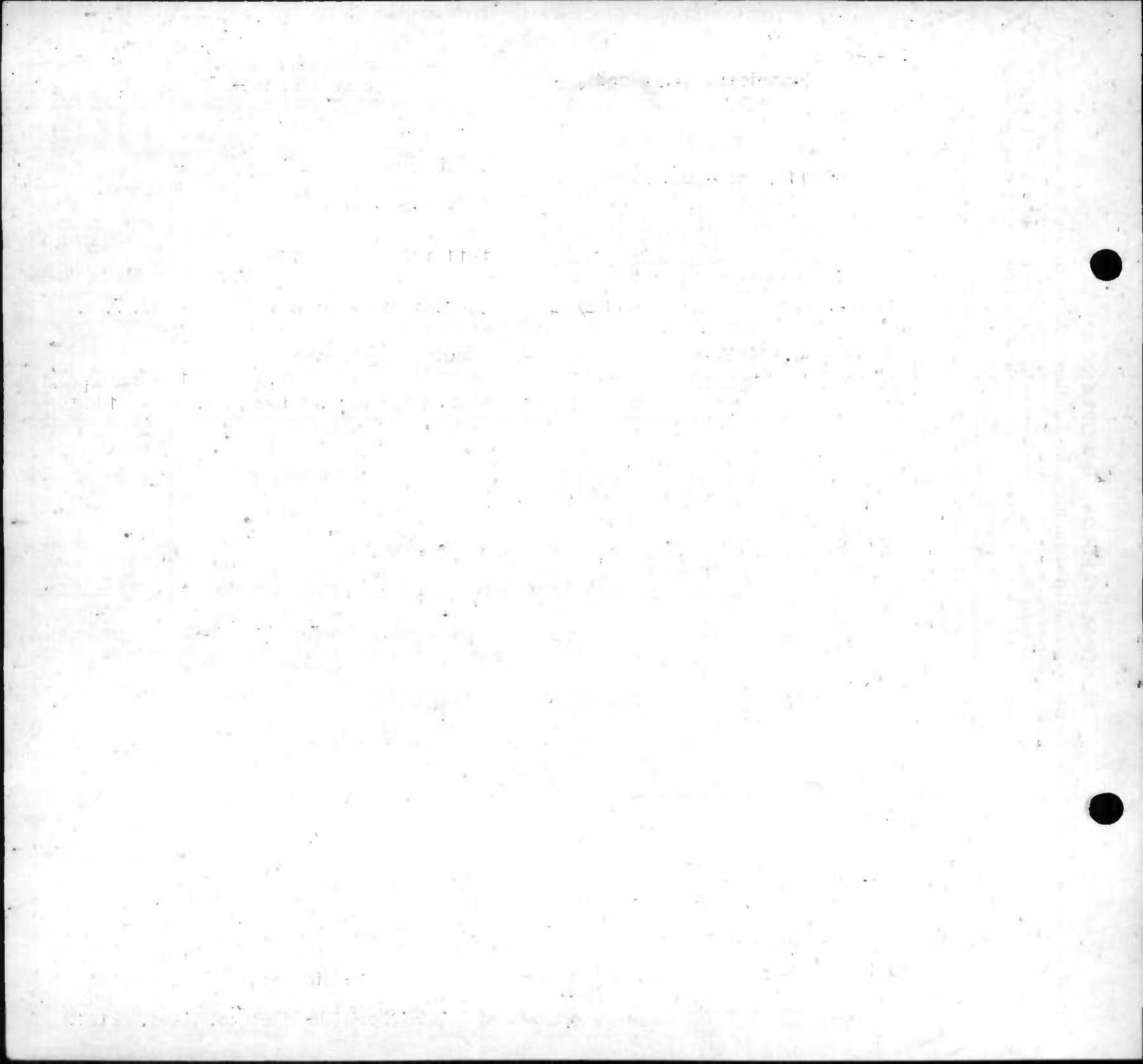
5-3-5

19487

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 08190 24	
BIRTH NO. 08190 24				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Henrietta B. Noeth			2. DATE AND HOUR OF DEATH June 30, 1972 1 8:40 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3811 Canterbury Road			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 1201 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3811 Canterbury Road		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/10/1896	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry C. Becker			14. MOTHER'S MAIDEN NAME Louise Wagner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-0942	17. INFORMANT 8219 ADDRESS Carrbridge Ct 21204 Mrs. Eugene L. Miles, Jr.		
18. 4369 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic obstructive Pulmonary disease 3 years			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 5/8/72 19 to 6/30/72 19, that (I) (we) last saw the deceased alive on 6/29/72 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis W. Gluck MD			23B. DATE SIGNED 7/1/72		23C. PHYSICIAN'S NAME (Type) Francis W. Gluck
23D. ADDRESS 100 W. University PKwy			23E. DATE REC'D BY HEALTH DEPT. JUL 3 1972		
23F. NAME OF REGISTRAR Sidney H. Hinton			23G. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		
23H. ADDRESS 4905 York Road Balto., Md. 21212			23I. DATE 7/3/72		
23J. NAME OF CEMETERY OR CREMATORY New Cathedral			23K. LOCATION (City, town, or county) (State) Baltimore, Maryland		



FUNERAL DIRECTOR: IMPORTANT

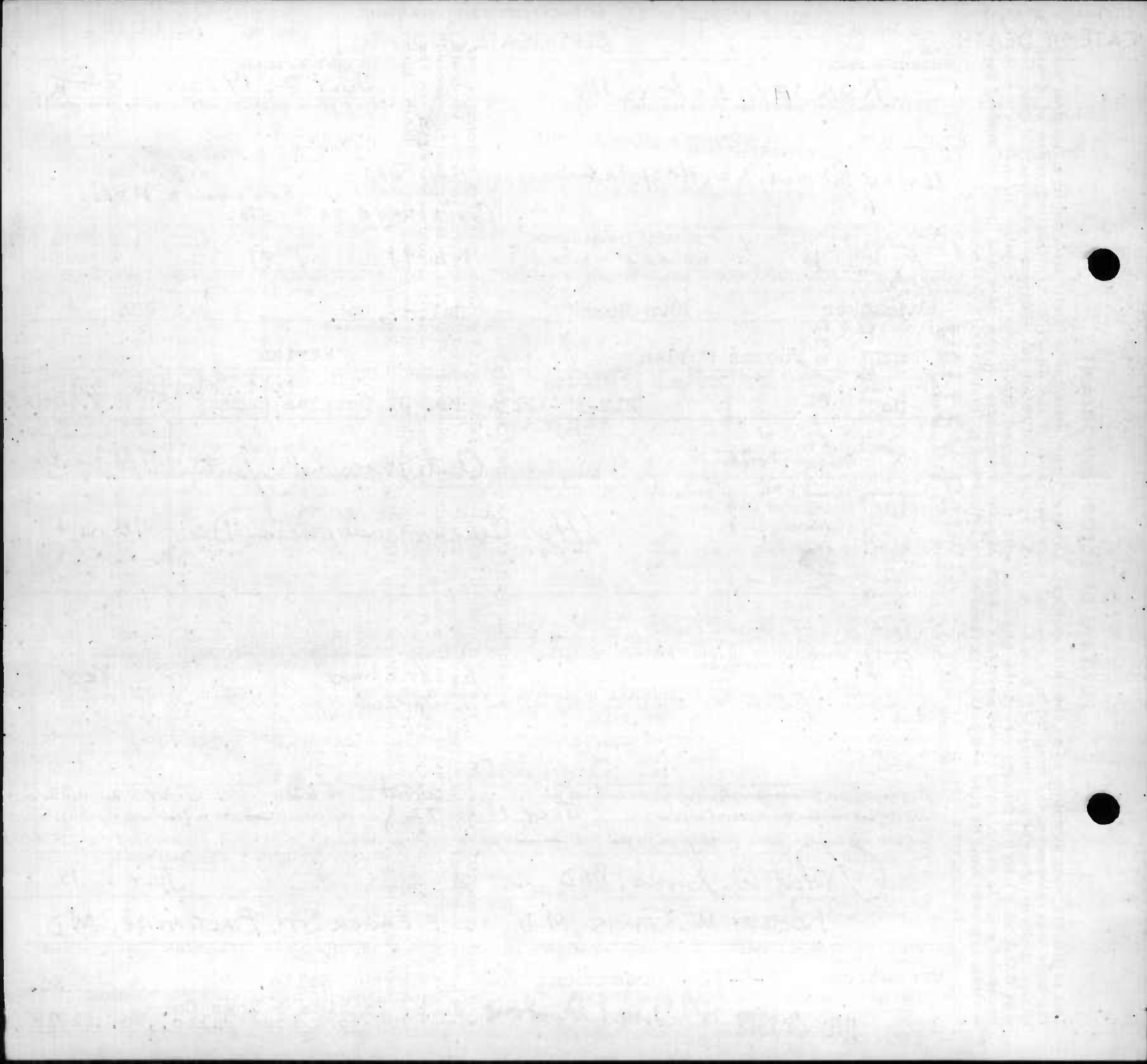
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DEM CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 06181

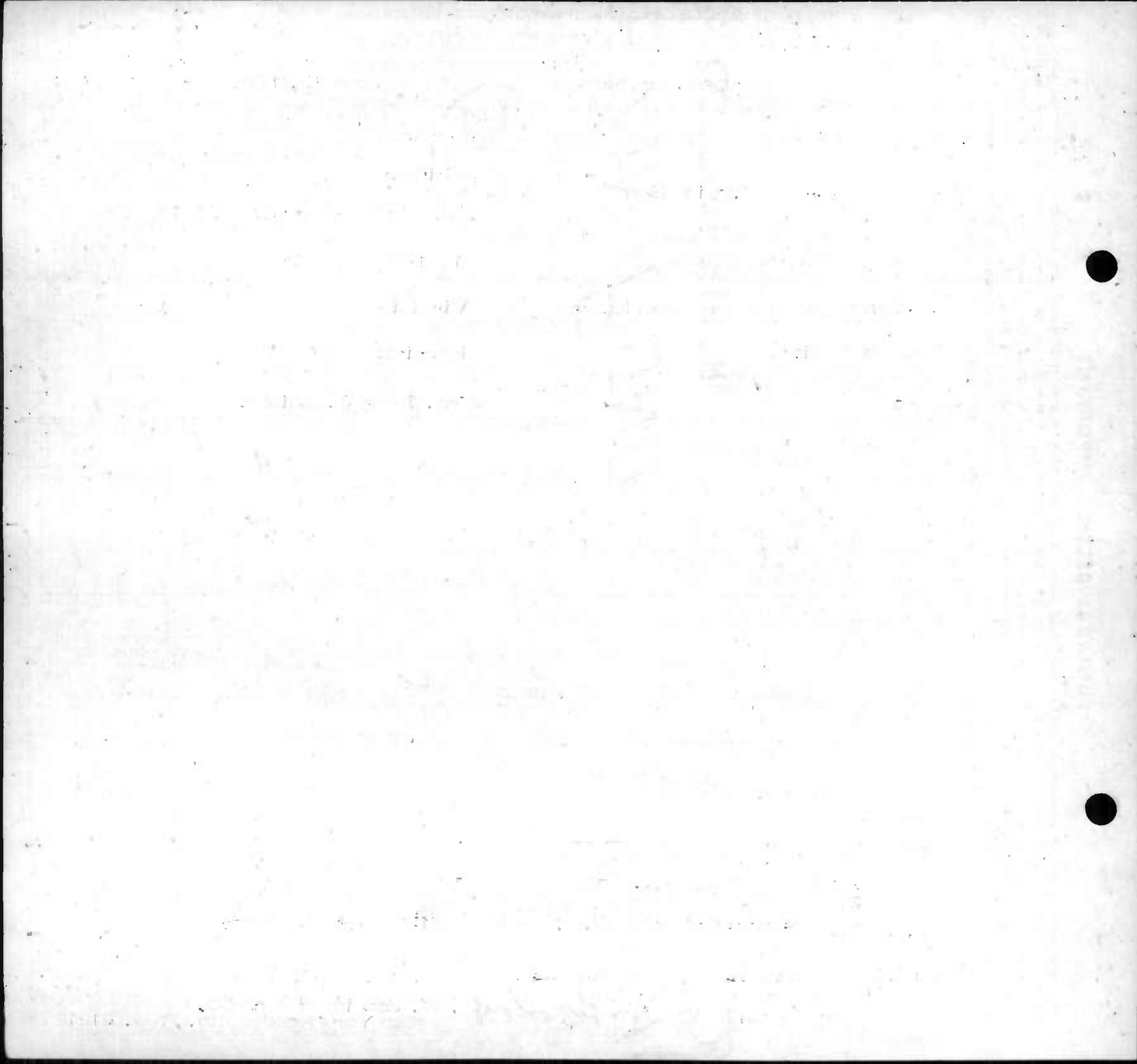
BIRTH NO. 72 06181		2. DATE AND HOUR OF DEATH JULY 2, 1972 8 ⁵⁰ A. M.	
1. NAME OF DECEASED (Type or Print) <u>Ramsay, Helen M.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u> <u>44</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u>		E. STREET AND NUMBER <u>AMBASSADOR APTS. CANTERBURY 4 39th STS.</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-16-91</u> 9. AGE (In years last birthday) <u>81</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Mullan</u>		14. MOTHER'S MAIDEN NAME <u>Marian</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-38-1213A</u>	
17. INFORMANT <u>Mr. J. Douglas Ramsay</u>		ADDRESS <u>Miami, Florida 33150</u>	
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <u>Acute Myocardial Infarction</u> (B) <u>Hypertension Cardiovascular Dis.</u> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>10 yrs. +</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES - HT. & LUNGS</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>about</u> 19 <u>62</u> to <u>JULY 2, 1972</u> , that (I) (we) last saw the deceased alive on <u>JULY 1, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Robert W. Garis, M.D.</u>		23B. DATE SIGNED <u>JULY 2, 19</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROBERT W. GARIS, M.D.</u>		23D. ADDRESS <u>12 E. EAGER ST., BALTIMORE, MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>7-5-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>	
25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Road Balto., Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DEMH BALTIMORE CITY HEALTH DEPARTMENT				72 06182		REG. NO. 72 06182	
BIRTH NO. 72 06182				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Maude I. Breeden				2. DATE AND HOUR OF DEATH June 29, 1972 11 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Kenesaw Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2204 Pinewood Avenue 21214			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1893	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Ennis				14. MOTHER'S MAIDEN NAME Harriett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Irene E. Shipley		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from June 19 71 to June 29, 19 72, that (I) (we) last saw the deceased alive on June 29, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Abram Goldman, M.D. 23B. DATE SIGNED 6/30/72 23C. PHYSICIAN'S NAME (Type) Abram Goldman M.D. 23D. ADDRESS 4123 Frederick Road 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 7-3-72 24C. NAME OF CEMETERY or CREMATORY Parkwood 24D. LOCATION (City, town, or county) (State) Parkville, Md. 25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972 25B. NAME OF REGISTRAR Sidney W. Jenkins 25C. FUNERAL DIRECTOR W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6201 72 06183		STATE OF MARYLAND - DEPARTMENT OF HEALTH		CERTIFICATE OF DEATH		REG. NO. 72 06183	
BIRTH NO.		1. NAME OF DECEASED J. Thomas Burke		2. DATE AND HOUR OF DEATH 6/30/72 - 5 a.m.		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Md.		B. COUNTY Baltimore	
90 Edgewood Nursing Home 6000 Bellona Ave. Baltimore, Md. 21212				C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 54 Shipway							
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/17/12	
				9. AGE (In years lost birthday) 60		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John C. Burke				14. MOTHER'S MAIDEN NAME Alice M. Covey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-07-0839		17. INFORMANT Wife: Mrs. Elizabeth Burke	
				ADDRESS 54 Shipway Dundalk, Md. 21222			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH -			
ANTECEDENT CAUSES				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRAIN Malignancy Metastasis - 2 mos -			
				(B) CARCINOMA - lung - 6 mos -			
				(C) MYOCARDIAL Infarction - 24 RS -			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6/28/72 to 6/30/72, that (I) (we) last saw the deceased alive on 6/30/72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Anthony F. Carozza						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Anthony F. CAROZZA						23D. ADDRESS 5217 York Rd Baltimore Md 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-3-72		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Maryland							
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972				25B. NAME OF REGISTRAR Sydney H. ...		25C. FUNERAL DIRECTOR John J. Duda	
				ADDRESS 7922 Wise Ave.		Dundalk, Md. 21222	

BALTIMORE CITY HEALTH DEPARTMENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06183	
STATE OF MARYLAND - DEHE CERTIFICATE OF DEATH					
BIRTH NO. 172 06183					
1. NAME OF DECEASED (Type or Print) RODGERS, Beverly J.			2. DATE AND HOUR OF DEATH 6/28/72 12:35a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2545 Lodge Forest Drive		
5. SEX Female	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/06/41	9. AGE (In years last birthday) 30	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James Goodman			14. MOTHER'S MAIDEN NAME Mabel Schackelford		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-38-2192		17. INFORMANT (Mother) 3107 Independence Ave. Mrs. Mabel Goodman, Balto. Md. 21218
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Recurrent Metastatic Carcinoma of the Cervix</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> </div>					
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None</p>					
19A. DATE OF OPERATION 6/1/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel Obstruction		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/19 1972 to 6/28 1972 , that (I) (we) last saw the deceased alive on 6/27 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julien Meyer				23B. DATE SIGNED 6/28/72	
23C. PHYSICIAN'S NAME (Type) Julien Meyer, M.D.				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/72		24C. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	
24D. LOCATION (City, town, or county) (State) Bel Air, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Sidney W. Houston		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.	

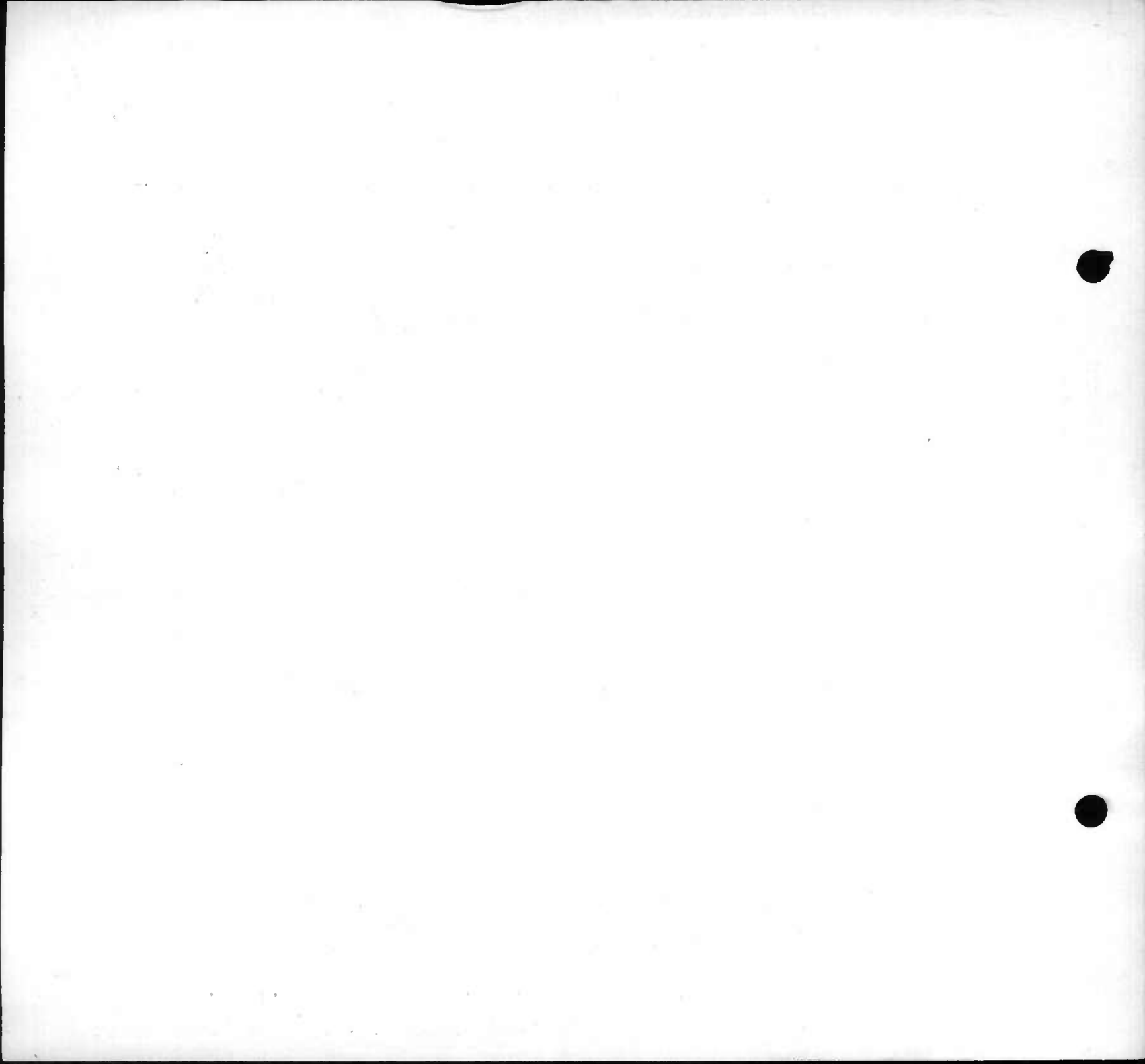
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPT. OF HEALTH		BALTIMORE CITY HEALTH DEPARTMENT	
72 06185		72 06185	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>SWANSON, EUGENE F.</u>		2. DATE AND HOUR OF DEATH <u>7/2/72</u> <u>6⁰⁰ am.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1601</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSPITAL OF MARYLAND</u> <u>730 ASHBURTON ST.</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1113 W. LANVALE ST.</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-08</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD WORK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>B+O</u>	9. AGE (in years last birthday) <u>63 years.</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. CITIZEN</u>	
13. FATHER'S NAME <u>SWANSON, BENJAMIN</u>		14. MOTHER'S MAIDEN NAME <u>SWANSON, MARTHA -</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WIFE & 1ST GUN</u>		ADDRESS <u>Bertha Swanson 1113 Lanvale St.</u> <u>3203 Phelps Lane Balto.</u>	
18. <u>427.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia? Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pre-existing CARDIAC IRREGULARITIES</u> (C) <u>Operation of Colectomy</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>6-29-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Aggravated Internal Bleeding</u>	
20A. AUTOPSY? (Yes or No) <u>Agreed to yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that <u>it</u> (this hospital) attended the deceased from <u>6-29</u> 19 <u>72</u> to <u>7-2</u> 19 <u>72</u> that <u>it</u> (we) last saw the deceased alive on <u>7-2</u> 19 <u>72</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>it</u> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Famutlwa</u>		23B. DATE SIGNED <u>7-2-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>OLUFUNSHO FAMUTLWA</u>		23D. ADDRESS <u>730 Ashburton St</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-6-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Weston</u>	
25C. FUNERAL DIRECTOR <u>V. Bailey</u>		ADDRESS <u>1348 Calhoun Street</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 00188

BIRTH NO. 72 00188

1. NAME OF DECEASED

(Type or Print)

ESTELLE ROULHAC

2. DATE AND HOUR OF DEATH

7-1-72 10:45 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

GRANADA Nursing Home
4017 Liberty Hgts Ave

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE MD

D. INSIDE CITY LIMITS

YES ☒

NO ☐

E. STREET AND NUMBER

1951 W-North Ave.

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

2-11-07

9. AGE (In years last birthday)

65 YRS

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HORACE SPENCE

14. MOTHER'S MAIDEN NAME

Idia Burrell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Adell Hill

ADDRESS

1951 W. North Ave.

18. 43671

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

CEREBROVASCULAR ACCIDENT

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/18/71 19 to 7/1/72 19 that (I) (we) last saw the deceased alive on 7/1/72 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hollis Greenberry, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

HOLLIS GREENBERRY, M.D.

23D. ADDRESS

1801 GREENBERRY RD, BALTIMORE MD

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-5-72

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Pk.

24D. LOCATION

Balta., Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 3 1972

25B. NAME OF REGISTRAR

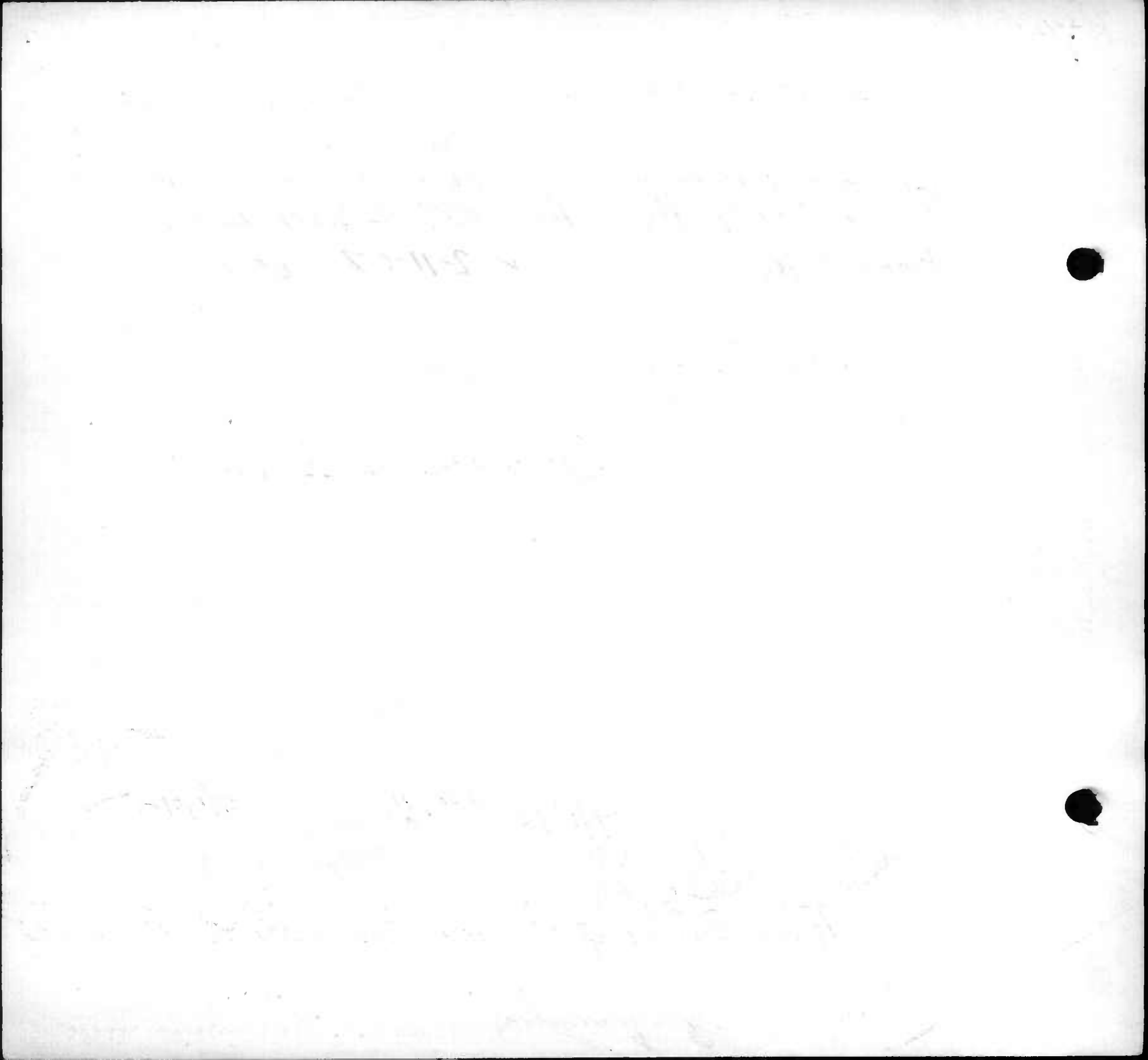
Andrew Houston

25C. FUNERAL DIRECTOR

V. Bailey

ADDRESS

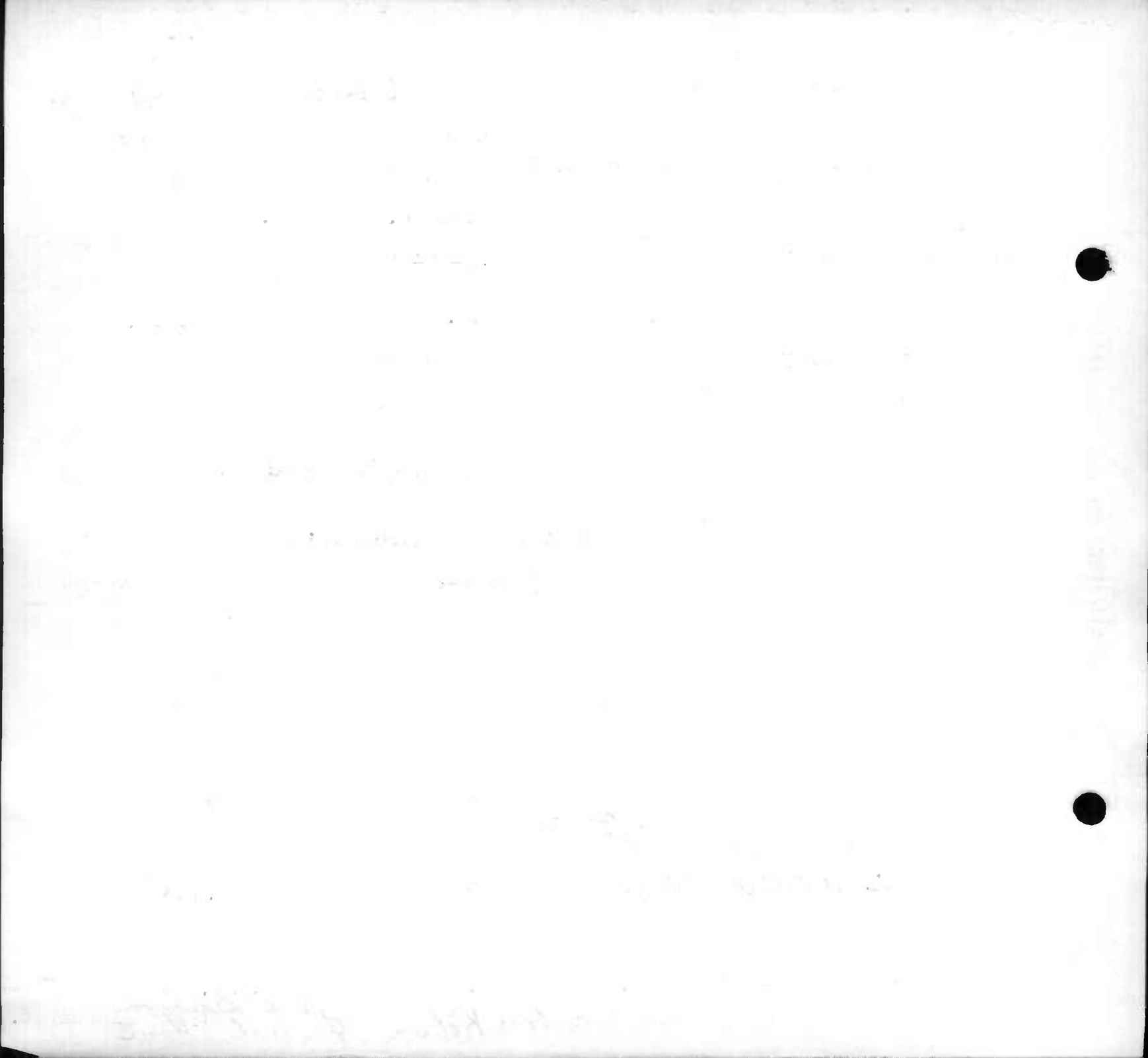
Kelson M.H. 1348 Calhoun Street



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DEMH				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06187	
BIRTH NO. 72 06187				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Estella Maiden				2. DATE AND HOUR OF DEATH 6/30/72 3 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Good Samaritan Hospital 45				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1601			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1123 N. Carey St.			
5. SEX Female	6. RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-07-97		9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Bailey				14. MOTHER'S MAIDEN NAME Caroline Nottingham			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Vincent Maiden		ADDRESS same	
18. 2307 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Nephrotic Syndrome DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
				(B) Diabetic nephropathy DUE TO, OR AS A CONSEQUENCE OF:		2 yrs	
				(C) Diabetes		yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/7/72 19 to 6/30/72 19 that (I) (we) lost saw the deceased alive on 6/30/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. Orer MD.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/30/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Adrienne Weston		25C. FUNERAL DIRECTOR V. R. Bailey		ADDRESS 1348 Calhoun St.	



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72 00188

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72-6188
72 00200
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MAUDE PALMER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1648 N. Warwick		3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1972 3:05 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1503	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7-11-14		10. AGE (In years last birthday) 57	11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 215127560		18. INFORMANT Joseph Palmer	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1648 N. Warwick 1503	
22D. TIME OF INJURY (APPROX.) 6-28-72 or 6-29-72		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot self	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 30, 1972	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Sidney H. Heston	
25C. FUNERAL DIRECTOR Kelson F.H.		25D. ADDRESS 1348 Calhoun Street			

RECORDS EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX AND COLOR

EDUCATION

RELIGION

72 06188

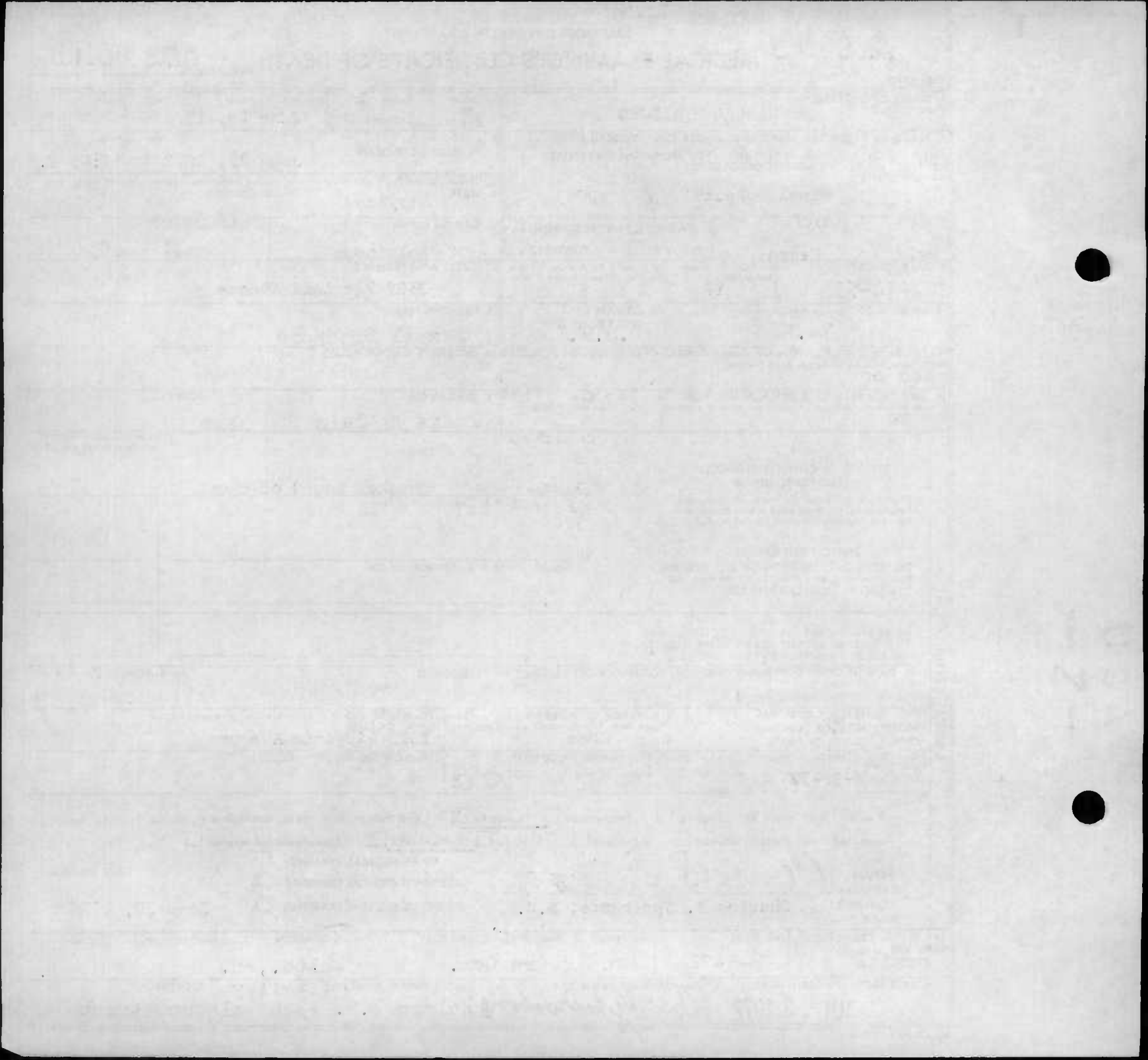
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

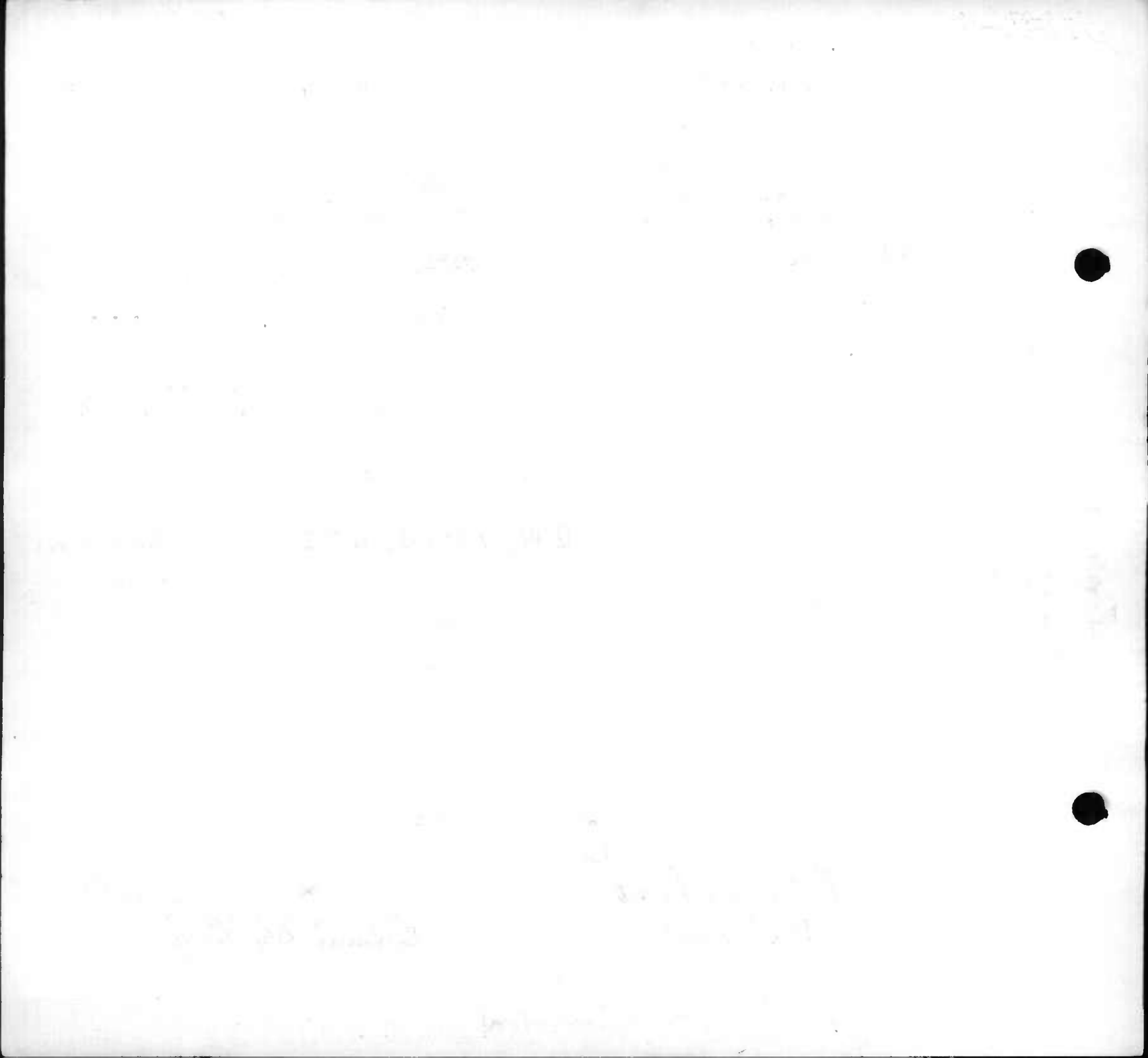
REG. NO.

72 06188

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SAMUEL BRADFORD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 29, 1972		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year June 29, 1972		Hour 12:05 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1513					
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 7-14-55		10. AGE (In years, lost birthday) 17 16		E. STREET AND NUMBER 3529 Virginia Avenue	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Bradford	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Gladys McClain same	
19. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 7-5-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3529 Virginia Avenue 1513	
22D. TIME OF INJURY (APPROX.) 6-29-72 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? ?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 30, 1972	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.	
				24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Sidney H. Houston		25C. FUNERAL DIRECTOR Bailey Kelson F.H. 1348 Calhoun Street	





33/3

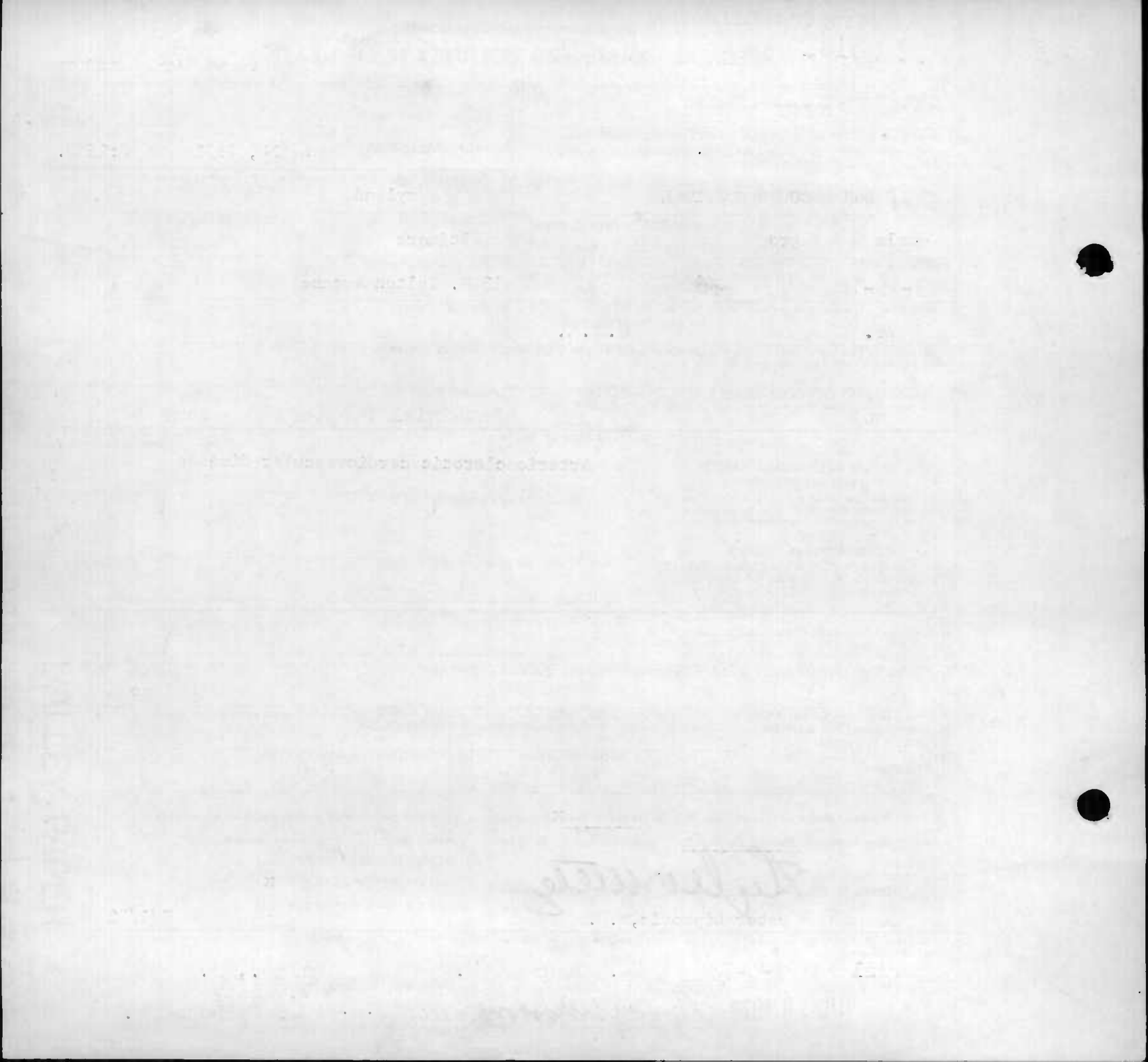
72 06191

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06191

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DAISY STEPTER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year June 30, 1972 Hour M. 9:25 P.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1901			
6. SEX Female	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3-19-16		10. AGE (In years last birthday) 56 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Nathaniel Stepter		ADDRESS same	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/1/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 7-6-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1972		25B. NAME OF REGISTRAR Audrey [Signature]	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

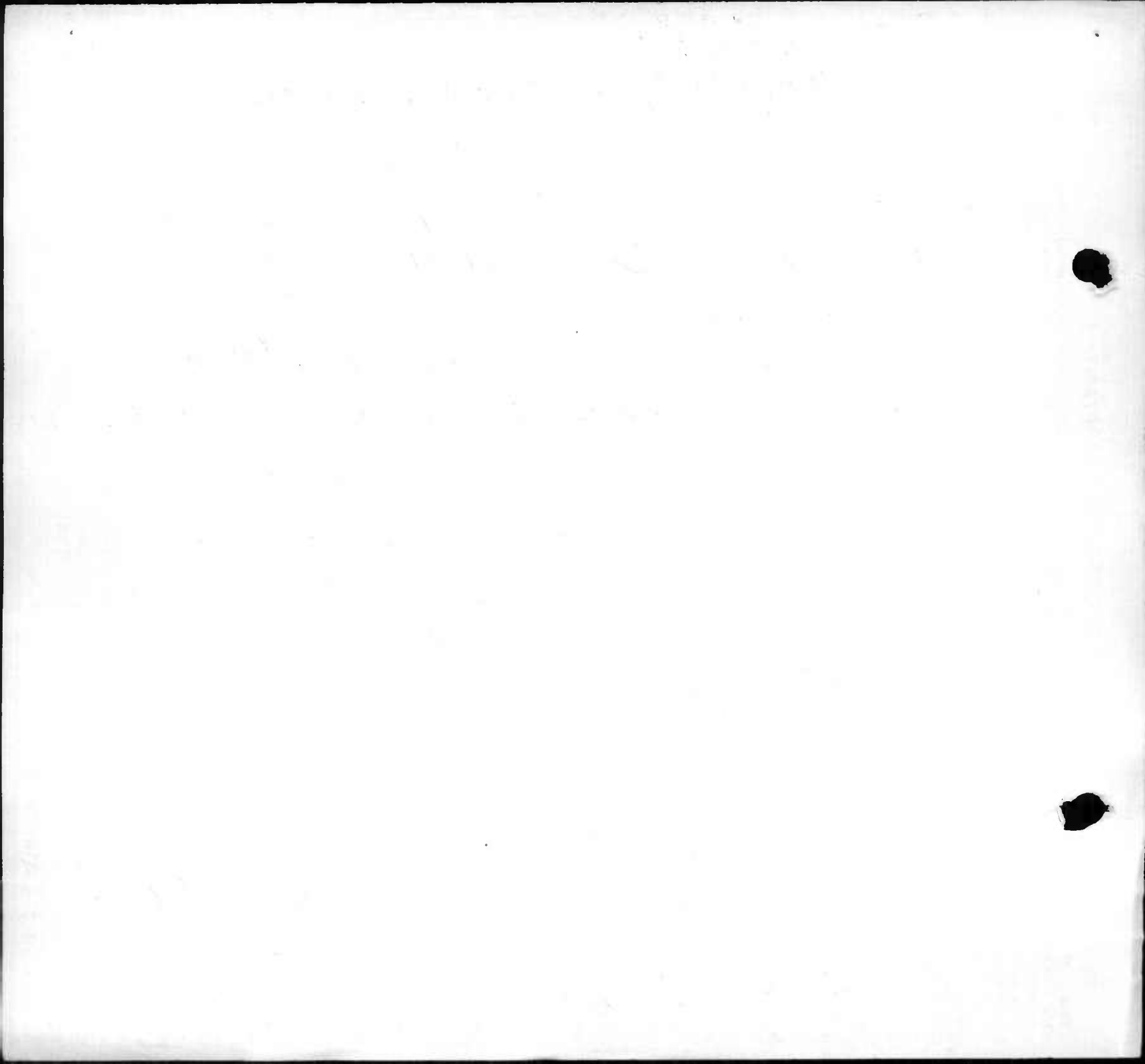
BIRTH NO. OF MARYLAND DEPT. OF HEALTH				72 06192		REG. NO.		72 06192	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Elsie STANFIELD				7/2-72				9:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224				A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4940 Eastern Ave. 21224					
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/20	9. AGE (in years last birthday) 51	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lafayette LAWSON				14. MOTHER'S MAIDEN NAME Martha ELLen					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT 4940 Eastern Ave. ADDRESS Baltimore, Md. 21224 BCHRecords:			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Osteomyelitis - Fever (B) DUE TO, OR AS A CONSEQUENCE OF: Multiple Sclerosis (C) DUE TO, OR AS A CONSEQUENCE OF: Chronic pancreatitis					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/2/70 19 to 7/2/72 19 that (I) (we) lost saw the deceased alive on 7/1/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Peter Dorsen				23B. DATE SIGNED 7/2-72		23C. PHYSICIAN'S NAME (Type) Peter Dorsen M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-7-72		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972				25B. NAME OF REGISTRAR Elliott Funeral Home		25C. FUNERAL DIRECTOR 1129 N. Carolina			

No other address available

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

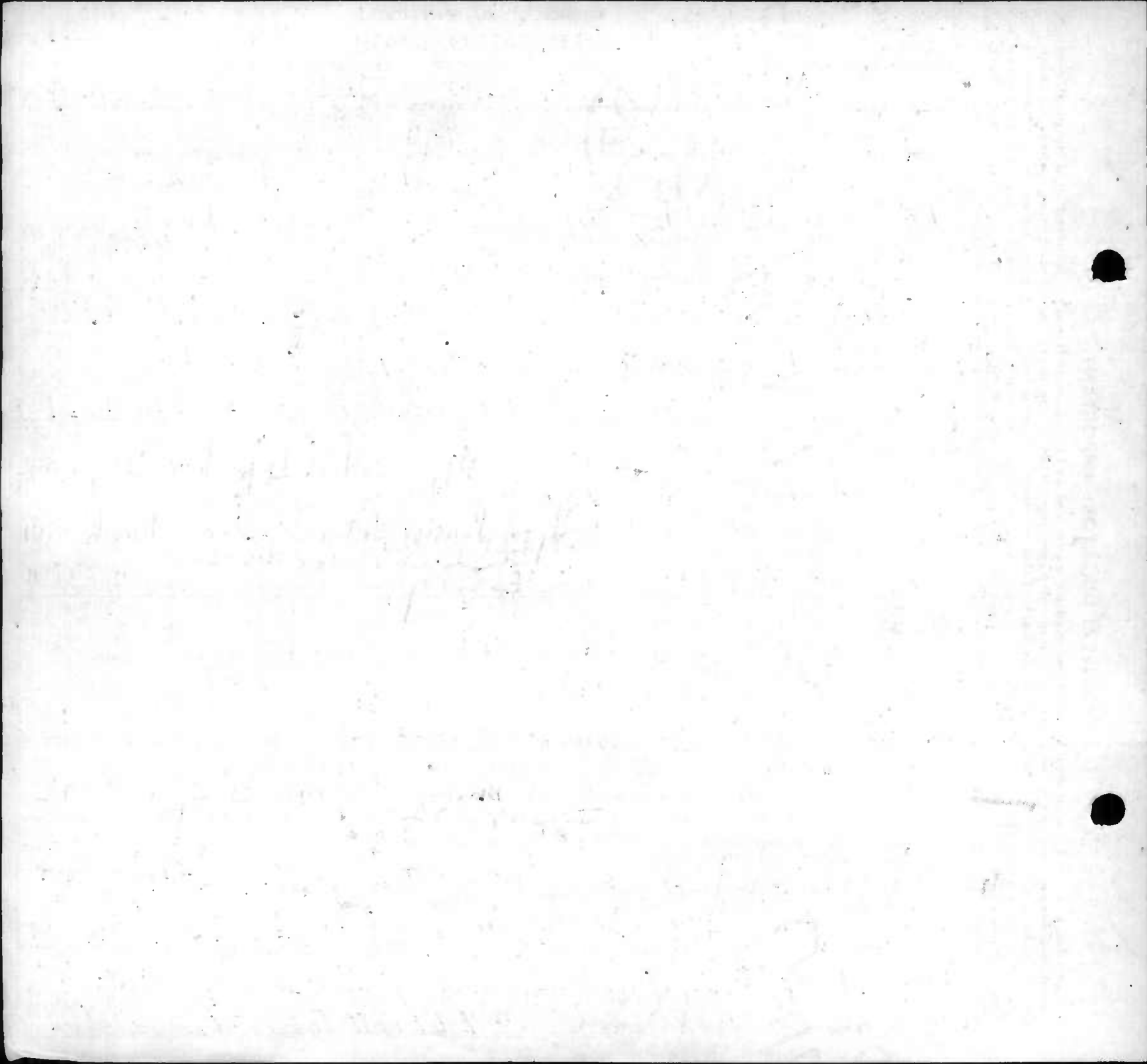
P-632		72 06193		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06193	
BIRTH DATE OF MARYLAND-DEATH				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PRITCHETT, JOSEPHINE Rev.				2. DATE AND HOUR OF DEATH 7/1/72 9 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) GOOD SAMARITAN HOSP, BALT				A. STATE MD B. COUNTY Belt City			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2079 E. Biddle St.			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01-01-00		9. AGE (In years last birthday) 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (NONE) Minister-Religious				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Carolina	
13. FATHER'S NAME Semone? SUMMERVILLE				14. MOTHER'S MAIDEN NAME Gandy, LAURA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO				16. SOCIAL SECURITY NO. 218-10-3665		17. INFORMANT ADDRESS Laurie Hicks-3707 Park View Ave.	
18. 2509 I				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-respiratory arrest			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Chronic and acute renal failure DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Diabetes mellitus			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				AK amputation			
19A. DATE OF OPERATION 6/5/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene @ foot		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? Inotify medical examiner NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/1/72 19 to 7/1/72 19 that (I) (we) last saw the deceased alive on 7/1/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. J. Arnold Jr MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/1/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-6-72		24C. NAME OF CEMETERY or CREMATORY MT. Calvary Cem.	
24D. LOCATION A. A. County		24E. (City, town, or county) Md.		24F. (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Andrew Johnson		25C. FUNERAL DIRECTOR ELLIS Funeral Home		25D. ADDRESS 1129 N. Carolina	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

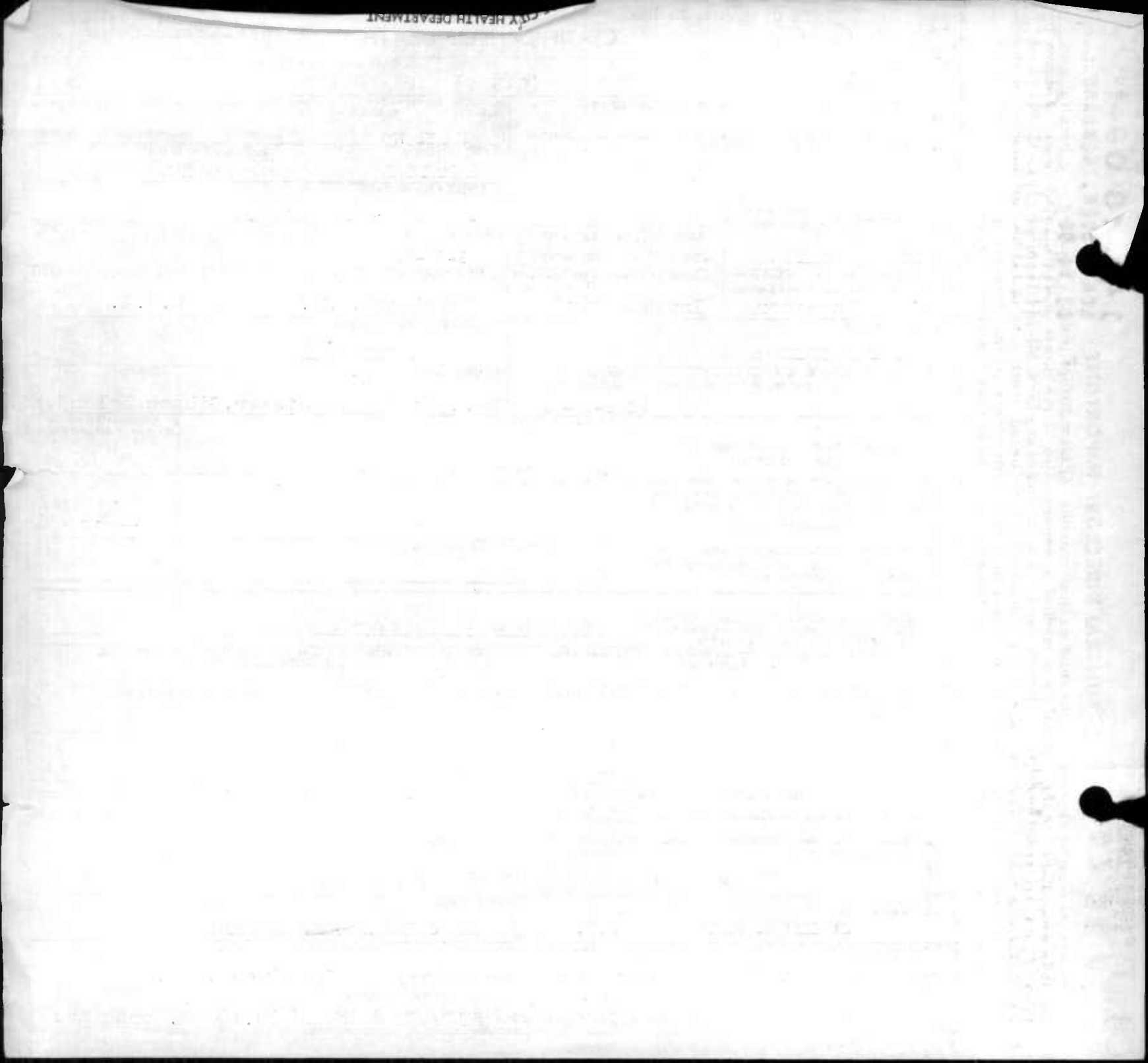
B-650 72 06194				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06194	
1. NAME OF DECEASED (Type or Print) Major Brown Sr.				2. DATE AND HOUR OF DEATH July 1, 1972 6:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 1826 N. Chapel St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 806			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1826 N. Chapel St.			
5. SEX M.	6. RACE C.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-07-19	9. AGE (In years last birthday) 52	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Samuel Brown			
14. MOTHER'S MAIDEN NAME Mary Shields				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 718-12-9431				17. INFORMANT Frances Brown-1826 N. Chapel St.			
18. 277X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH July 1, 1972				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Hypertensive Arteriosclerotic DUE TO, OR AS A CONSEQUENCE OF: March 1971			
				(C) Obesity 4 1971			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 1971 to July 1, 1972 , that (I) (we) last saw the deceased alive on June 29, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE T.D. Thier MD				23B. DATE SIGNED 7/3/72			
23C. PHYSICIAN'S NAME (Type) T.D. Thier MD				23D. ADDRESS 1228 N. Carroll St. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-5-72		24C. NAME OF CEMETERY OR CREMATORY BALTO. Cemetery		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Ellen F. Farnham		25C. FUNERAL DIRECTOR ELL F. Farnham		ADDRESS 1129 N. Caroline St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE				REG. NO. 72 06 95	
BIRTH NO. 72 06 95				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>SCHMEISSER, GERHARD L. (LAUTS)</u>			2. DATE AND HOUR OF DEATH <u>7/3/72</u> <u>12</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1201</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
BALTIMORE, MD 21205			E. STREET AND NUMBER <u>3900 N. CHARLES STREET</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-14-90</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Investor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Investments</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>ERNST SCHMEISSER</u>		
14. MOTHER'S MAIDEN NAME <u>A. LOUISE GAIL</u>			15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>213-20-8607</u>			17. INFORMANT <u>son:</u> ADDRESS <u>Dr. Gerhard Schmeisser, Gibson Island, Md.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>039.91</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Sepsis Shock</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>? 24 hrs.</u> <u>2 days</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Anemia + Leukopenia</u>			?		
19A. DATE OF OPERATION <u>2/1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>1972</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/3/72 9 AM</u> 19 <u>72</u> to <u>7/3/72 12 M</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>7/3/72 12 M</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Judith E. Karp, MD</u>				23B. DATE SIGNED <u>7/3/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>JUDITH E. KARP</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>7/5/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Green Mount Crematory</u>	
24D. LOCATION <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1972</u>		25B. NAME OF REGISTRAR <u>Sidney B. Houston</u>		25C. FUNERAL DIRECTOR <u>STEWART & MOWEN CO.</u>	
				ADDRESS <u>108 W. North Ave (1)</u>	



JMK 6321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 06198

4

BIRTH NO. 72 06198 72-09318		1. NAME OF DECEASED (Type or Print) BREITSCHWERDT, BABY BOY		2. DATE AND HOUR OF DEATH JUNE 16, 1972 3:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN ELKRDIGE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7060 WASHINGTON BLVD			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/15/72	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD BREITSCHWERDT			14. MOTHER'S MAIDEN NAME CARMEN MORALES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT BALTO MD 21229 ADDRESS ST AGNES' RECORDS CATON & WILKENS AVES		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work 21F. HOW DID INJURY OCCUR? 22. I certify that (X) (this hospital) attended the deceased from JUNE 15 19 72 to JUNE 16 19 72, that (X) (we) last saw the deceased alive on JUNE 16 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. 23A. SIGNATURE [Signature] 23B. DATE SIGNED 23C. PHYSICIAN'S NAME (Type) AZAD GABER 23D. ADDRESS BALTO MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVE 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 6/30/72 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972 25B. NAME OF REGISTRAR Lindsey H. Weston 25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue ADDRESS					

FUNERAL DIRECTOR: IMPORTANT

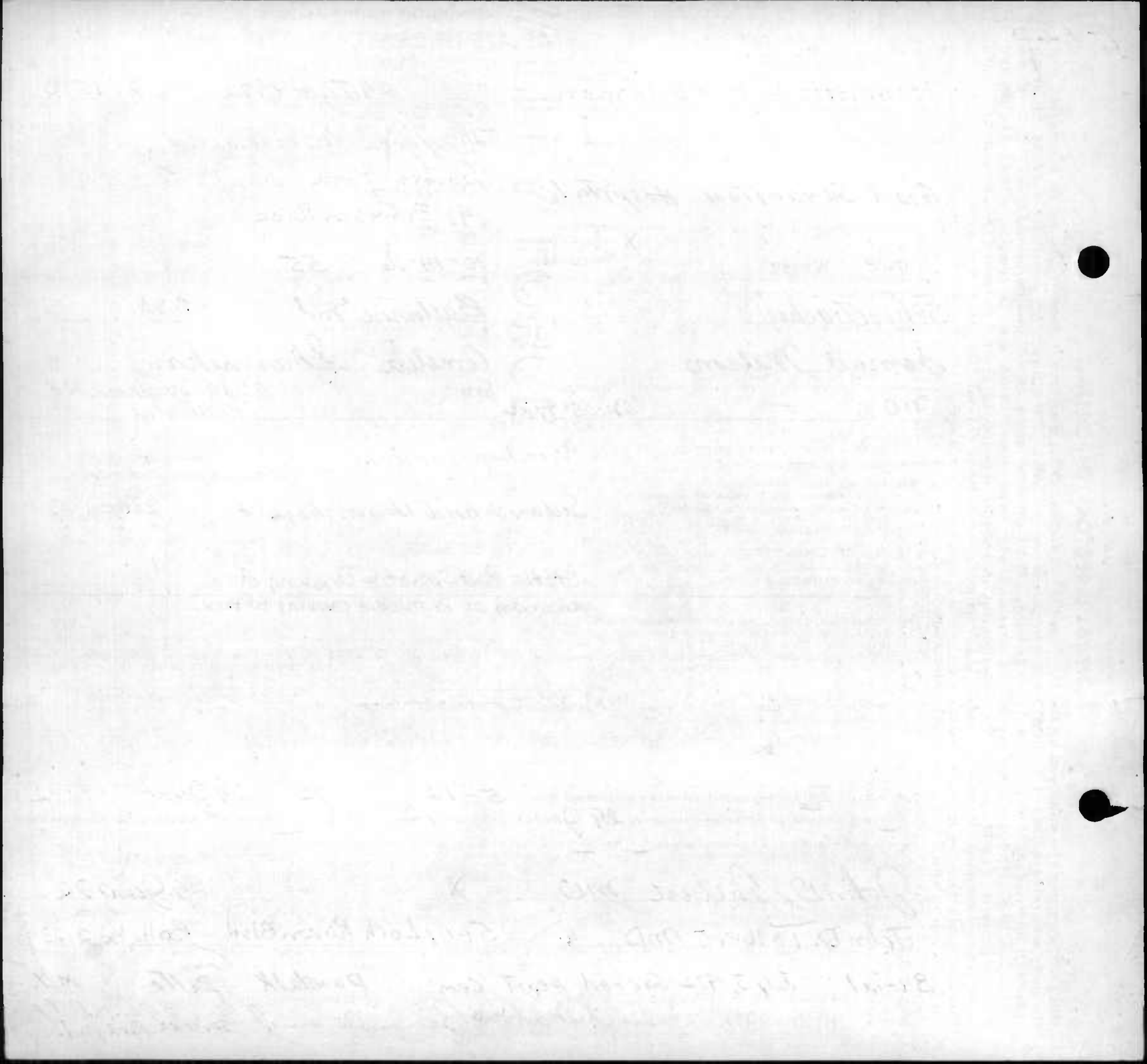
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

INFORMATION
DATE: 10/10/1973
TIME: 10:10
TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

FUNERAL DIRECTOR: IMPORTANT

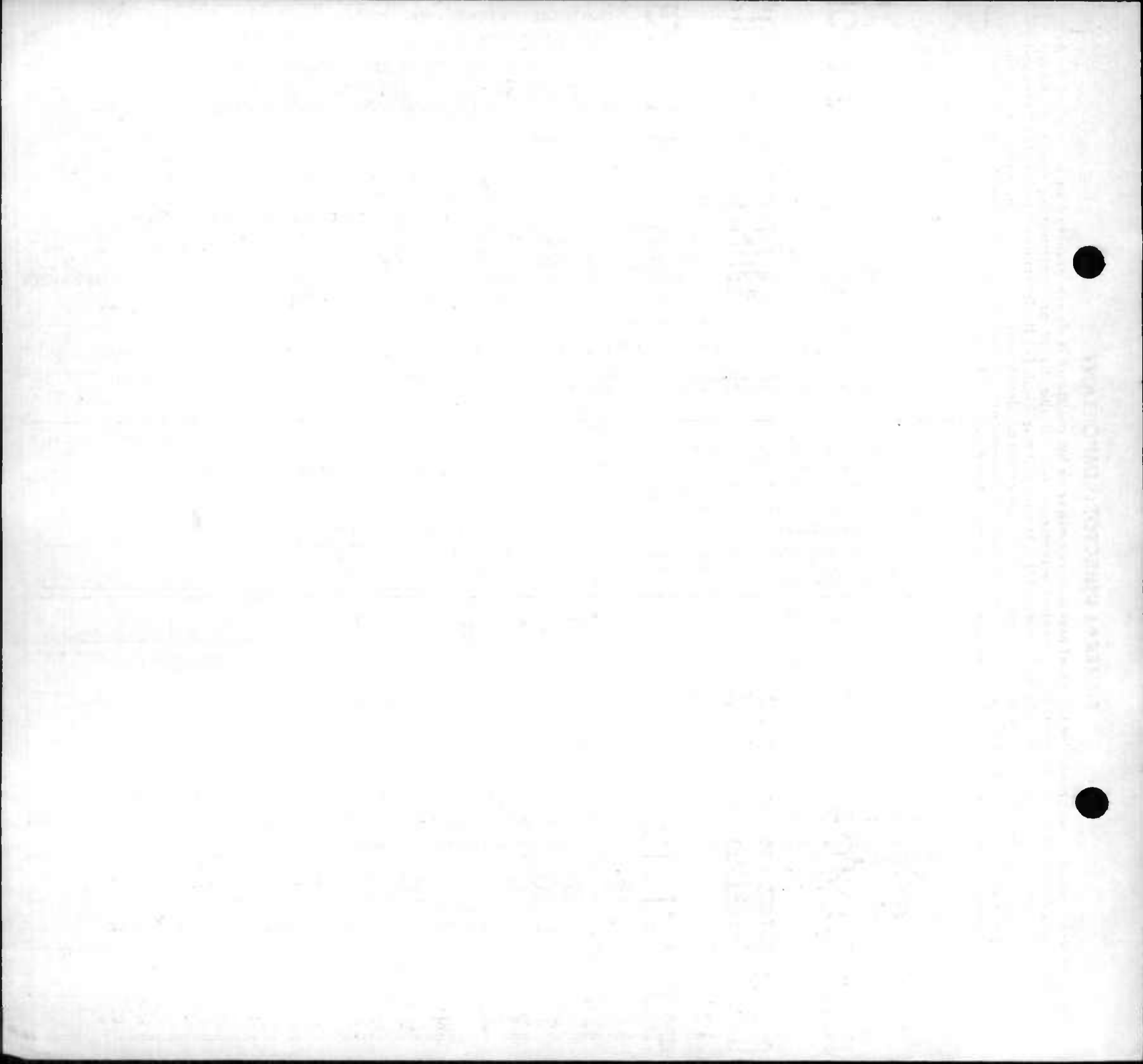
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEMO BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06197	
BIRTH NO. 72 06197				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Henrietta L. Huebschman</i>			2. DATE AND HOUR OF DEATH <i>29 June 1972 2:15 p.m.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Good Samaritan Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i> C. CITY OR TOWN <i>Savanna Park</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>41 Emerson Road</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-14-16</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
13. FATHER'S NAME <i>Samuel Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Amelia Sharmahan</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>220-05-7726</i>		17. INFORMANT <i>Son</i> ADDRESS <i>5249 Saybrook Rd. Baltimore</i>	
18. <i>430.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Bronchopneumonia</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Subarachnoid Hemorrhage +</i> <i>Status Post Operative Clipping of</i> <i>Aneurysm of Rt. middle cerebral artery</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>23 April 72</i> <i>1</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5-12 1972</i> to <i>29 June 1972</i> , that (I) (we) last saw the deceased alive on <i>29 June 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John D. Talbert, MD</i>				23B. DATE SIGNED <i>29 June 72</i>	
23C. PHYSICIAN'S NAME (Type) <i>John D. Talbert, MD</i>				23D. ADDRESS <i>5601 Loch Raven Blvd. Baltimore 21239</i>	
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 3, 1972</i>		24C. NAME of CEMETERY or CREMATORY <i>Sacred Heart Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>Pandalk Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1972</i>			
25B. NAME OF REGISTRAR <i>Audrey Whorton</i>		25C. FUNERAL DIRECTOR <i>3333 ...</i>			
ADDRESS <i>41 Emerson Road</i>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEMH BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06198 4	
BIRTH NO. 72 06198 4				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BABY GIRL GONZALEZ			2. DATE AND HOUR OF DEATH 6/29/72 8:15		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 2748		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP 37RD AND CALVERT ST			C. CITY OR TOWN BALTO. MD		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1119 GLENEAGLE RD		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-29-72	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME BENJAMIN GONZALEZ			14. MOTHER'S MAIDEN NAME MARIE LATHAM GONZALEZ		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT HELEN LATHAM ADDRESS 1119 GLENEAGLE RD	
18. 776.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RESPIRATORY INSUFFICIENCY (B) IMMATURITY DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CNS BLEED					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/29 7:25 PM 19 72 to 8:15 PM 6/29/72 that (I) (we) last saw the deceased alive on 6/29 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Stephen Dubansky MD			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 6/29/72	
23C. PHYSICIAN'S NAME (Type) A. STEPHEN DUBANSKY			23D. ADDRESS UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7-3 72	24C. NAME of CEMETERY or CREMATORY St Marys Hampden	24D. LOCATION Baltimore Md	ICity, town, or county (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Andrew Whitton	25C. FUNERAL DIRECTOR Frank H. Kelly		ADDRESS 814 N 36 St

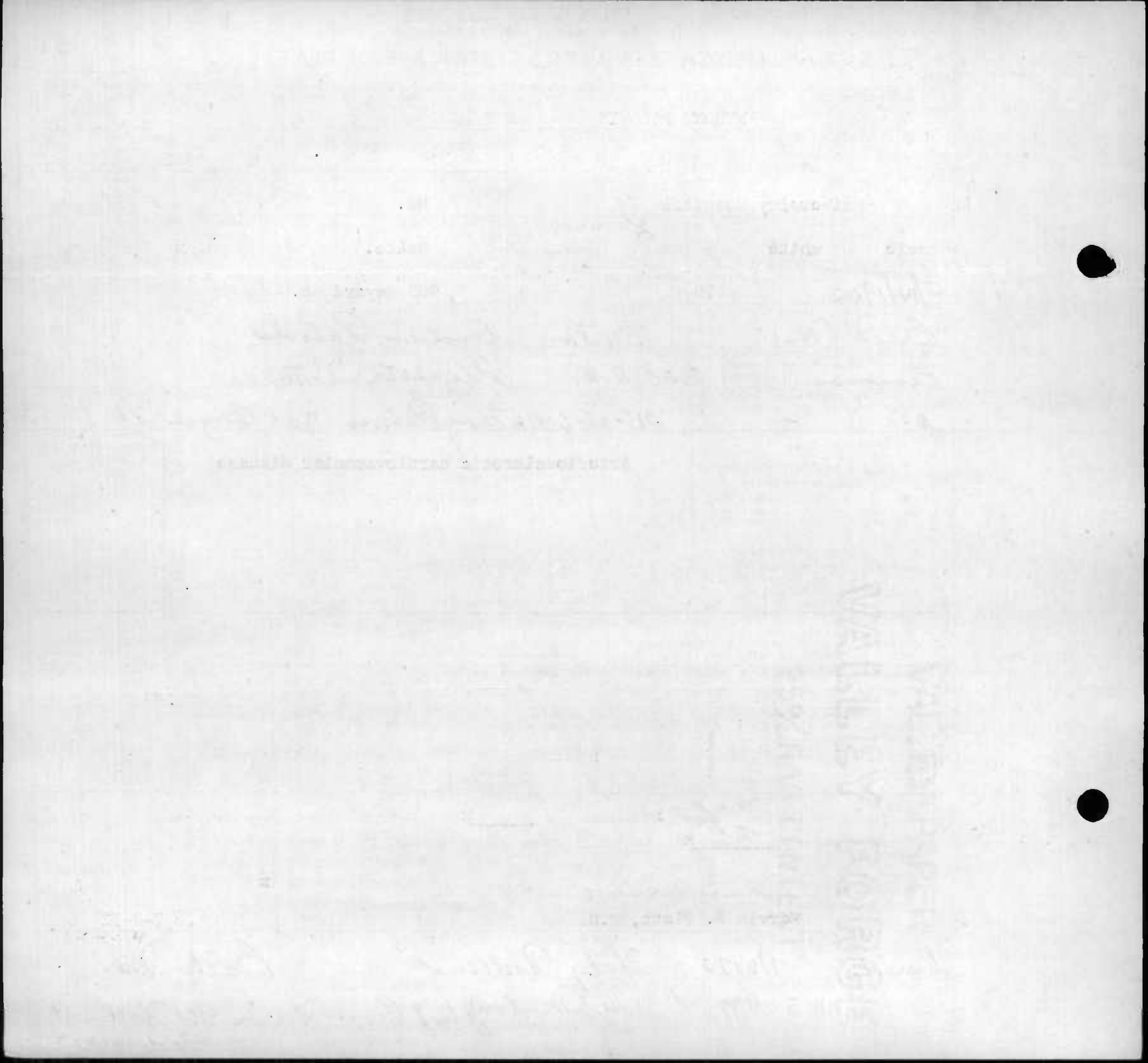


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANTHONY PALOVIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 2 1972 6:15 p.m.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2102	
9. DATE OF BIRTH 2/14/1902		10. AGE (In years last birthday) 70	
11. BIRTHPLACE (State or foreign country) Baeb. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personnel		14B. KIND OF BUSINESS OR INDUSTRY B & O. R. R.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-05-6081A	
18. INFORMANT Tracy Palovis		ADDRESS 903 Bayard St. 21223	
19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 21		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Marvin S. Platt, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-3-72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 7/6/72	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baeb. Md.	
25A. DATE REC'D BY HEALTH DEPT. 1111 5 1972		25B. NAME OF REGISTRAR Sidney H. Heston	
25C. FUNERAL DIRECTOR John J. Cowan - Son Inc.		ADDRESS 901 Hallens St. Baeb. 21223	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DEME BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 06200

BIRTH NO. 72 06200

1. NAME OF DECEASED
(Type or Print)

LITOFISKY, LEON

2. DATE AND HOUR OF DEATH

7-1-72

11:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MD

BALTO

C. CITY OR TOWN

RANDALLSTOWN

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

9 SPINNERS COURT Apt 1A 21133

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

03-05-1907

9. AGE (In years last birthday)

65

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant

10B. KIND OF BUSINESS OR INDUSTRY

Retail

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Isaac Litofsky

14. MOTHER'S MAIDEN NAME

Reva

?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-03-9582

17. INFORMANT

ADDRESS

Md. 21133

Mrs. Sarah Litofsky 9 Spinners Ct. Randallstown

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

GLIOBLASTOMA

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-19 19 72 to 7-1 19 72 that (I) (we) last saw the deceased alive on 7-1 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Peter Orszulian

MD DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7-1-72

23C. PHYSICIAN'S NAME (Type)

PETER ORSZULIAN MD

23D. ADDRESS

3 HAMILL RD APT 5 21210

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/2/1972

24C. NAME of CEMETERY or CREMATORY

Moses Montifiore

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

III 5 1972

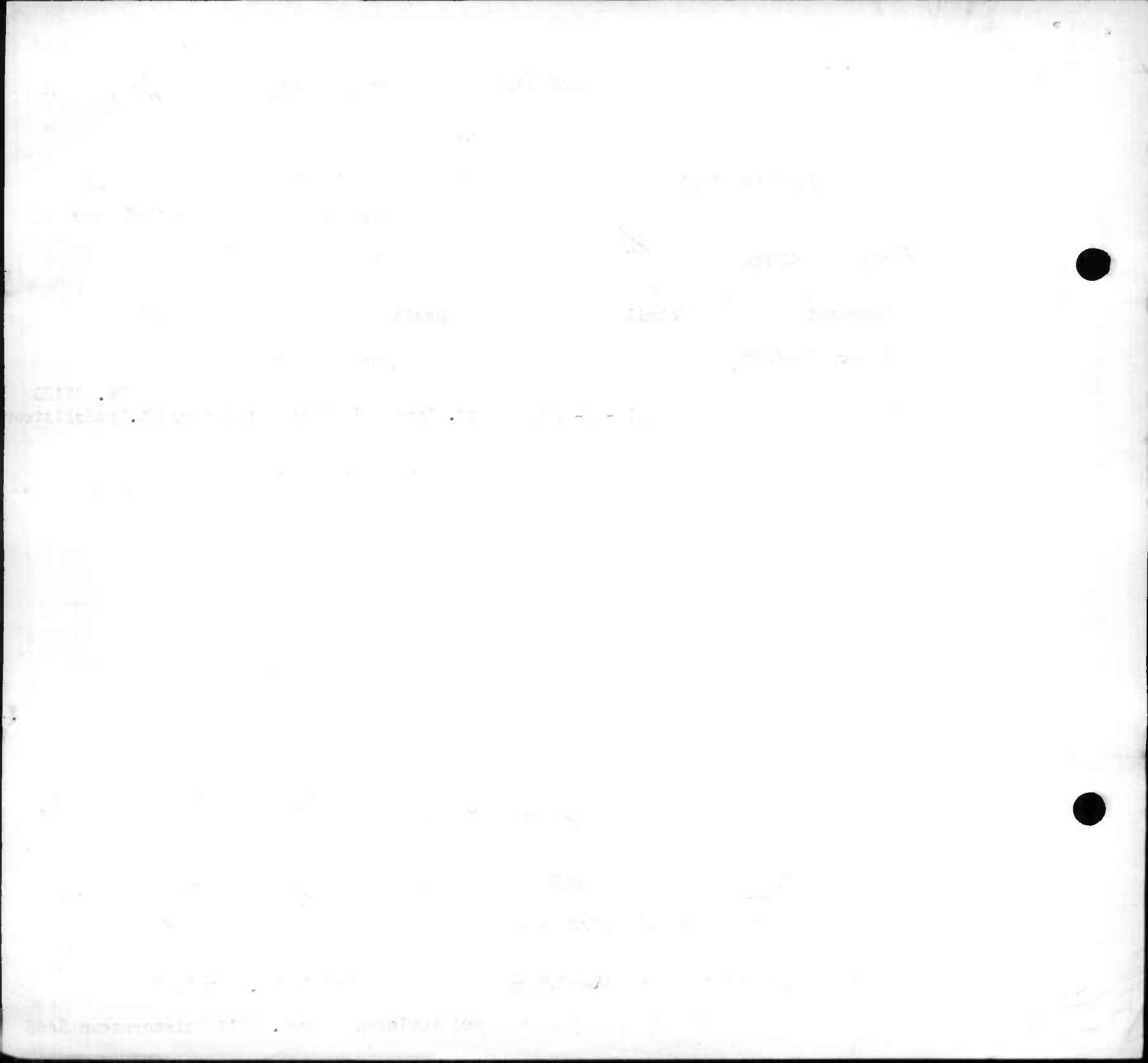
25B. NAME OF REGISTRAR

Andrew W. Wootton

25C. FUNERAL DIRECTOR

Sol Levinson & Bros. 6010 Reisterstown Road

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DHMH BALTIMORE CITY HEALTH DEPARTMENT									
72 06201					72 06201				
BIRTH NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) REICH, CHARLES					2. DATE AND HOUR OF DEATH 6/30/72 1 P M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSP.					C. CITY OR TOWN BALTIMORE				
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					E. STREET AND NUMBER 7 Slade Ave. 212 08				
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/10/86		9. AGE (In years last birthday) 85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10B. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE		11. BIRTHPLACE (State or foreign country) NEW YORK, NEW YORK			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME UNKNOWN Moritz Reich					14. MOTHER'S MAIDEN NAME UNKNOWN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 128-20-0669		17. INFORMANT Fran E. Okun MRS. JEROME OKUN, 7 SLADE AVE., APT. 211 #8				
18. 410.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Myocardial Infarction, 1 hr Coronary arterio sclerosis, years				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from June 24 19 72 to June 30 19 72 that (I) (we) last saw the deceased alive on June 30 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Jakob S. [Signature]					23B. DATE SIGNED June 30 72			23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS DEGREE					23E. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN P				
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL/BURIAL		24B. DATE 7/1/72		24C. NAME of CEMETERY or CREMATORY MT. HEBRON - TURA ZUKOW K			24D. LOCATION (City, town, or county) (State) FLUSHING LONE ISLAND, NEW YORK		
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972		25B. NAME OF REGISTRAR Arlene [Signature]			25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN P				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND—DHMH BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 72 06202					CERTIFICATE OF DEATH					
REG. NO. 72 06202										
1. NAME OF DECEASED (Type or Print) SARAH MEHLMAN					2. DATE AND HOUR OF DEATH Sat. July 1, 1972 10:00 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3913 Fordleigh Road					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3913 Fordleigh Road					
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 70		9. AGE (In years last birthday) 70 If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY At Home			11. BIRTHPLACE (State or foreign country) Russia			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Dubois					14. MOTHER'S MAIDEN NAME Ida Allen					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-32-0350		17. INFORMANT Mrs. Bernice Goldstein 2503 Apache Circle 21209				
18. 41221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertension Cardiovascular disease (A) IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF: 20 yrs II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					CAUSE OF DEATH Hypertension Cardiovascular disease (A) IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 11/15/55 19 to 7/1/72 19, that (I) (we) last saw the deceased alive on 11/14/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Milton B. Kirsh					23B. DATE SIGNED July 1, 1972			23C. PHYSICIAN'S NAME (Type) Milton B. Kirsh		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 7/2/1972		24C. NAME OF CEMETERY or CREMATORY Beth Isaac Adath Israel			
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972					25B. NAME OF REGISTRAR Sidney Levinson		25C. FUNERAL DIRECTOR Sgl Levinson & Bros. 6010 Reisterstown Road			
24D. LOCATION (City, town, or county) Baltimore, Maryland					24E. ADDRESS 4000 W. Northern Parkway					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DHMH				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06203	
BIRTH NO. 72 06203				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARY E. DIETER				2. DATE AND HOUR OF DEATH FRI. JUNE. 30, 72 3:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 72 SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2740 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6212 GREENSPRING AVE. 21209			
5. SEX F.M.	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 9, 1888	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? SPINDLER				14. MOTHER'S MAIDEN NAME JOSEPHINE ENGEL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-01-8666B		17. INFORMANT ADDRESS THOMAS E. PURDY 6212 GREENSPRING AVE. 21209			
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure Arteriosclerotic heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ----- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years Several years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1965 to June 30, 1972, that (I) was last saw the deceased alive on June 30, 1972 and that in (my) four opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.							
23A. SIGNATURE Seymour H Rubin				23B. DATE SIGNED 6/30/72			
23C. PHYSICIAN'S NAME (Type) DR. SEYMOUR RUBIN M.D.				23D. ADDRESS 5415 PARK HGTS. AVE. 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 3, 72		24C. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY		24D. LOCATION (City, town, or county) (State) PIKESVILLE, MD. BALTO. CO.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Loring Byers		25C. FUNERAL DIRECTOR'S ADDRESS LORING BYERS FUNERAL DIRECTORS P.A. 8728 LIBERTY ROAD, RANDALLSTOWN MD. 21133			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CHARLES W. BASSLER, Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month June Day 29 , Year 1972		Hour 1:35 P. M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) University Hospital		3. DATE PRONOUNCED DEAD Month June Day 29 , Year 1972		Hour 1:35 P. M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY AA				
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Glen Burnie
9. DATE OF BIRTH 1954 22 Sept. 1954		10. AGE (in years last birthday) 17	E. STREET AND NUMBER 1201 Astor Drive	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Charles W. Bassler, Sr.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaping		14B. KIND OF BUSINESS OR INDUSTRY Garden Center	15. MOTHER'S MAIDEN NAME Betty Urban	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 216-68-7510	18. INFORMANT ADDRESS Father, same as 5	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
21. AUTOPSY? (Yes or No) No				
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Early Road & State Rte. #2
22D. TIME OF INJURY (APPROX.) 6-15-72 1:52 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by auto
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 30, 1972				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3 July 72	24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Co., Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Sidney W. Boston	25C. FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md.	

#54-25147

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT						CERTIFICATE OF DEATH		REG. NO. <u>72 06205</u>	
BIRTH NO. <u>72 06205</u>		1. NAME OF DECEASED (Type or Print) <u>Carl Discher</u>				2. DATE AND HOUR OF DEATH <u>7/1/72</u> <u>9 30</u> A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>90 House in Pines Nursing Home</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2642</u>			
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>12/3/86</u>		9. AGE (In years last birthday) <u>85</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>						10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Frederick W. Discher</u>						14. MOTHER'S MAIDEN NAME <u>-</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>no</u> If yes, give war or dates of service						16. SOCIAL SECURITY NO. <u>220-30-0587</u>		17. INFORMANT <u>Julius Bronstein (Lawyer)</u> ADDRESS <u>704 Court Sq. Bldg.</u>	
18. <u>4/12/31-011.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) IMMEDIATE CAUSE <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>-</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>year</u>	
19A. DATE OF OPERATION <u>8/12/1969</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CAUSING DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the doctor) attended the deceased from <u>8/12/1969</u> to <u>7/1/1972</u> that (I) (we) last saw the deceased alive on <u>6/30/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.									
23A. SIGNATURE <u>Albert B. Bradley M.D.</u> DEGREE						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7/1/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Albert B. Bradley, M.D.</u> DEGREE						23D. ADDRESS <u>4900 Belair Road 21206</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/5/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		24D. LOCATION <u>Balto. Md.</u> (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>1111 5 1972</u>		25B. NAME OF REGISTRAR <u>A. Lewis</u>		25C. FUNERAL DIRECTOR <u>Schimmek Funeral Homes, Inc.</u> ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>					

Adm. 8/13/69

Pres. Address 4606 Chafford Ave.

THE BODY OF ERROLL UNION HAS BEEN RELEASED AS NON-MED BY

FUNERAL DIRECTOR: IMPORTANT
DR. L. PROVINC OF THE MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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Erroll, Erroll

STATE OF MARYLAND - DEPT. BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 06206

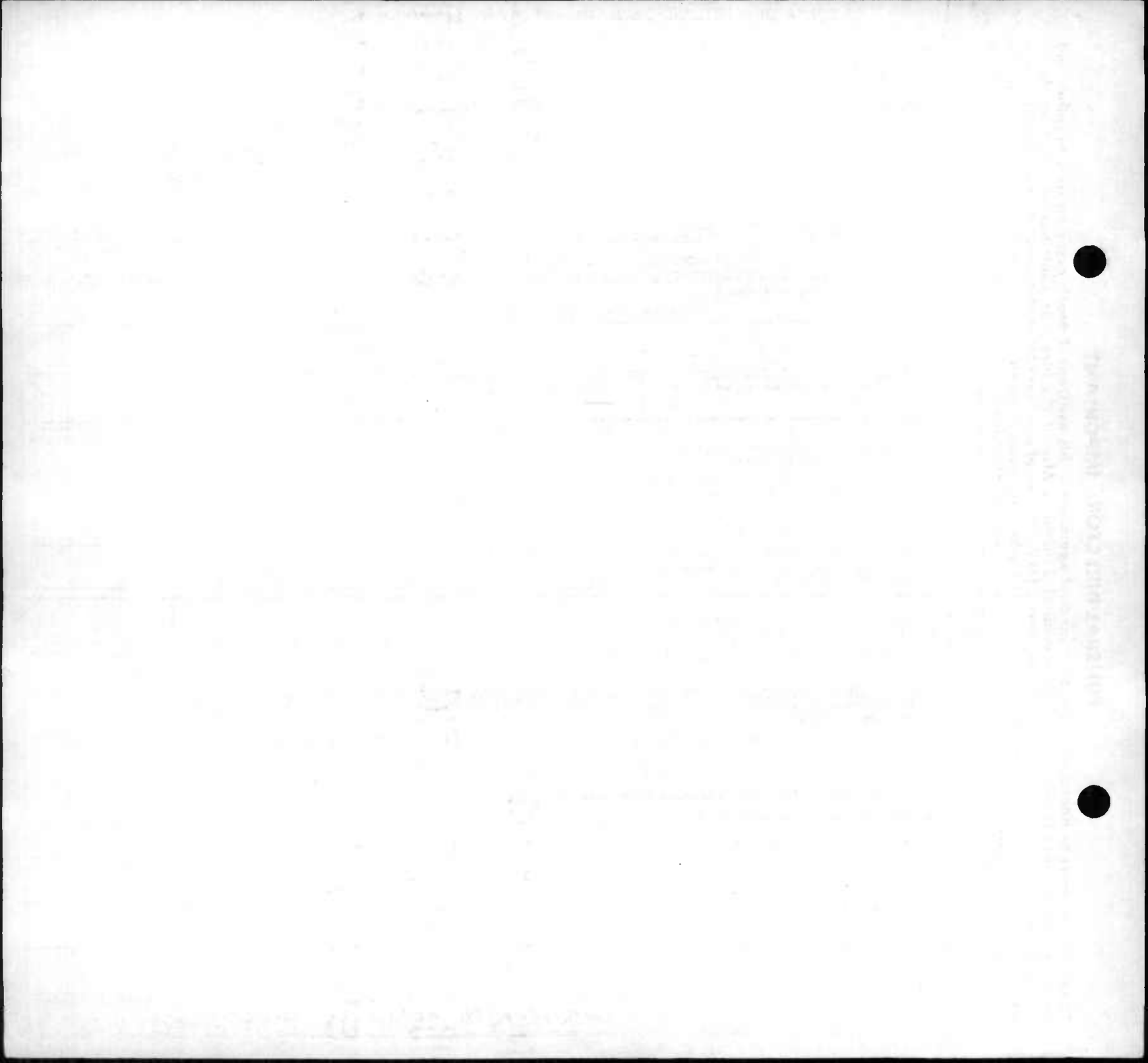
BIRTH NO. 72 06206		2. DATE AND HOUR OF DEATH 06-30-72 9:30 P.M.	
1. NAME OF DECEASED (Type or Print) ERROLL UNION		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 701	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 823 N. STREEPER STREET	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-05-09
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) spray painter-retired		10B. KIND OF BUSINESS OR INDUSTRY Bender Corp.	9. AGE (In years last birthday) 62
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Onion		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO. 219-16-5891	
17. INFORMANT Mrs. Edwin Ravage (dghtr)		ADDRESS 830 Harris Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Probably acute MI.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indefinite medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Nicholas A. Volpicelli		23B. DATE SIGNED 7/1/72	
23C. PHYSICIAN'S NAME (Type) NICHOLAS A. VOLPICELLI M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7/3/72	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	24D. LOCATION (City, town, or county) (State) Bal to. Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Sidney H. Weston	
25C. FUNERAL DIRECTOR Schimunek		ADDRESS 3337 Brehms Lane, Balto. Md. 21213	

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FUNERAL DIRECTOR: IMPORTANT

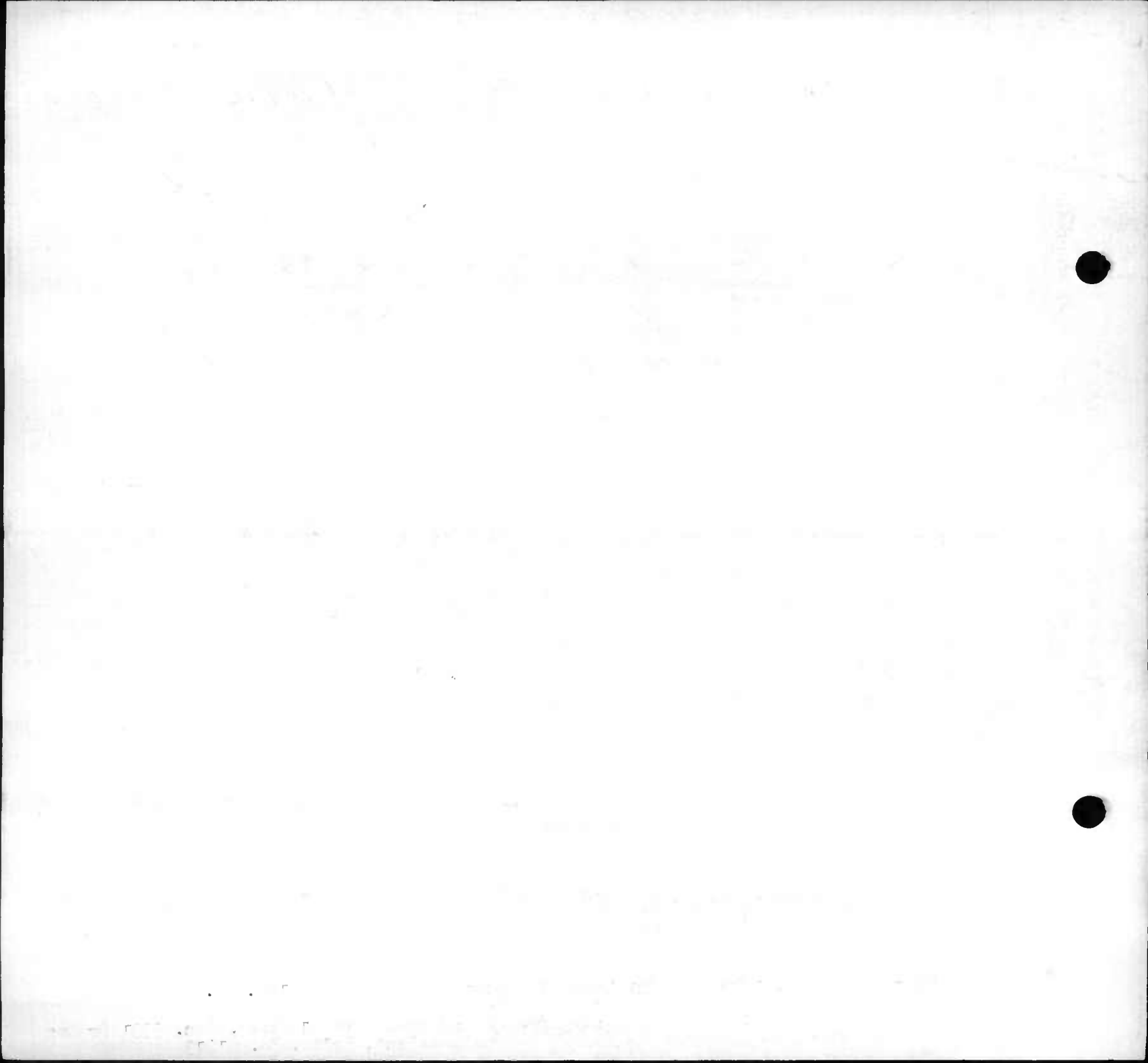
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEM BALTIMORE CITY HEALTH DEPARTMENT		72 06207	
BIRTH NO.		72 06207	
CERTIFICATE OF DEATH		REG. NO. 72 06207	
1. NAME OF DECEASED (Type or Print) <u>Lillian Fernandez</u>		2. DATE AND HOUR OF DEATH <u>29 June 72 1105 A</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u> <u>48</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1101 N. Calvert Street</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-17</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>	9. AGE (In years last birthday) <u>55</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Schaffer</u>		14. MOTHER'S MAIDEN NAME <u>Tina Filip</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Raymond Fernandez</u>		ADDRESS <u>1101 N. Calvert St., Baltimore Md</u>	
18. <u>199.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Bronchopneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bilateral</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinomatosis</u>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6-25</u> 19 <u>72</u> to <u>6-29</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>6-29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>JH Ziegler M.D.</u>		23B. DATE SIGNED <u>6/29/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>JH Ziegler, M.D.</u>		23D. ADDRESS <u>Maryland General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-1-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Houston</u>	
25C. FUNERAL DIRECTOR <u>Nicholas T. Matthews</u>		ADDRESS <u>3021 Eastern Ave., Baltimore, Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

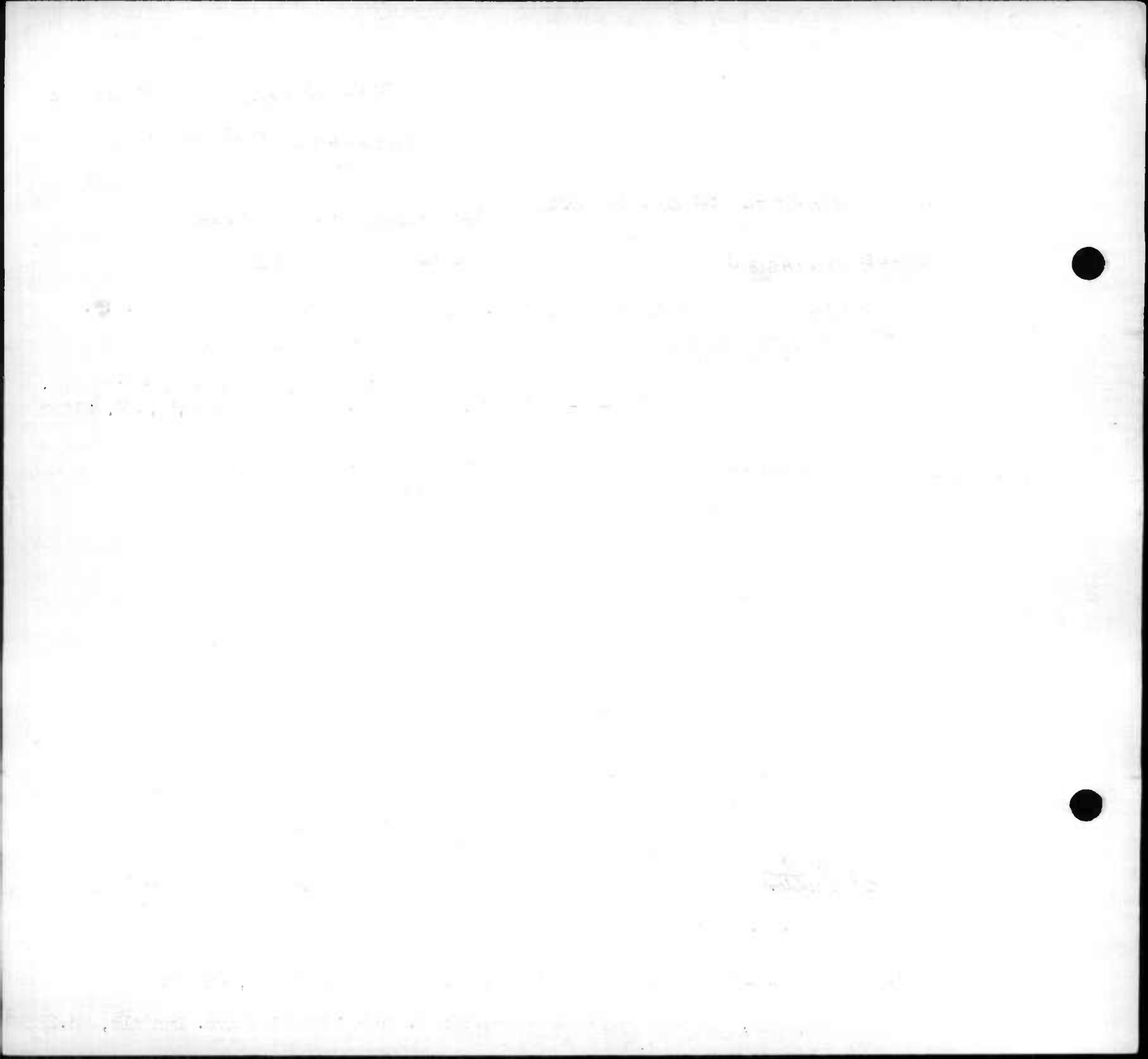
STATE OF MARYLAND-DHMH BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 06208	
BIRTH NO. 72 06208		1. NAME OF DECEASED (Type or Print) MR LEROY J. SENNETT		2. DATE AND HOUR OF DEATH 6/30/72 4:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL 35				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2758			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5729 NASCO PLACE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-00	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Hand		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John C SENNETT				14. MOTHER'S MAIDEN NAME NORA SPARKS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 195 05 9220		17. INFORMANT J. SADER		ADDRESS 100 N. Broadway 21231	
18. 412.3 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 6/23/72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Block of left femoral artery 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (A) IMMEDIATE CAUSE Ventricular Fibrillation ~ 10 hours - DUE TO, OR AS A CONSEQUENCE OF: A. S. H. D. & Block long standing (B) DUE TO, OR AS A CONSEQUENCE OF: left femoral artery (C) Post op care of left Sympathectomy & Thoracic - popliteal Bypass. 7 days				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-19-1972 to 6-30-1972 that (I) (we) last saw the deceased alive on 6/30-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Nabin Sader 70 DEGREE				23B. DATE SIGNED 6/30/72			
23C. PHYSICIAN'S NAME (Type) NABIN SADER				23D. ADDRESS 100 N. Broadway CH & H			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/3/72		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Sidney H. Weston		25C. FUNERAL DIRECTOR Schmitt Funeral Homes, Inc. 3331 Brehms		ADDRESS 100 N. Broadway 21231	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPARTMENT OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 06209	
BIRTH NO. 72 06209				1. NAME OF DECEASED (Type or Print) Irene F. Lane		2. DATE AND HOUR OF DEATH JUNE 27, 1972 10:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTO. INC.				MARYLAND Baltimore		5. CITY OR TOWN Essex B. COUNTY BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX FEMALE 6. RACE CAUCASIAN 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 11-21-19		9. AGE (In years last birthday) 52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production				10B. KIND OF BUSINESS OR INDUSTRY Martin Marietta Corp.		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Clifton Fowler		14. MOTHER'S MAIDEN NAME Thelma Porter	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 240-20-6506		17. INFORMANT Son: 2039 Shore Road, Dundalk, Md. 21222	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Carcinoma of breast c. widespread 1 yr 6 mos.			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF metastasis, bone liver, and Brain metastasis			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If yes, specify medical examination)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/5 to JUNE 27 19 72 that (I) (we) last saw the deceased alive on 6/27/72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. F. Sutton				23B. DATE SIGNED 6/27/72			
23C. PHYSICIAN'S NAME (Type) E. F. Sutton				23D. ADDRESS Sinai Hospital of Balto. Inc.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-1-72		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Baltimore, Maryland				25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Andrew W. Houston	
25C. FUNERAL DIRECTOR John J. Duda				25D. ADDRESS 7922 Wise Ave. Dundalk, Md. 21222			



CERTIFICATE OF DEATH

REG. NO. 72 06210

BIRTH NO. 72 06210

1. NAME OF DECEASED

(Type or Print)

Channell, Opal D

2. DATE AND HOUR OF DEATH

June 29, 1972

12MN

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

3700 Old North Point Road 21222

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7-9-31

9. AGE (In years
last birthday)

40

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

W. Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James E. Bodkins

14. MOTHER'S MAIDEN NAME

Attie White

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.
236-44-9544

17. INFORMANT

BCH Records

ADDRESS

4940 Eastern Avenue

Baltimore, Maryland 21224

18. 171.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 yrs

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-28-1972 to 6-29-1972
that (I) (we) last saw the deceased alive on 6-29-1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-29-72

23C. PHYSICIAN'S
NAME (Type)

R Genodry

DEGREE

23D. ADDRESS

4940 Eastern Avenue

Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Removal-Burial

24B. DATE

7/3/72

24C. NAME of CEMETERY or CREMATORY

Valley Head Cemetery

24D. LOCATION

(City, town, or county)

(State)

Randolph Co. West Virginia

25A. DATE REC'D BY HEALTH DEPT.

JUL 5 1972

25B. NAME OF REGISTRAR

Lidney Houston

25C. FUNERAL DIRECTOR

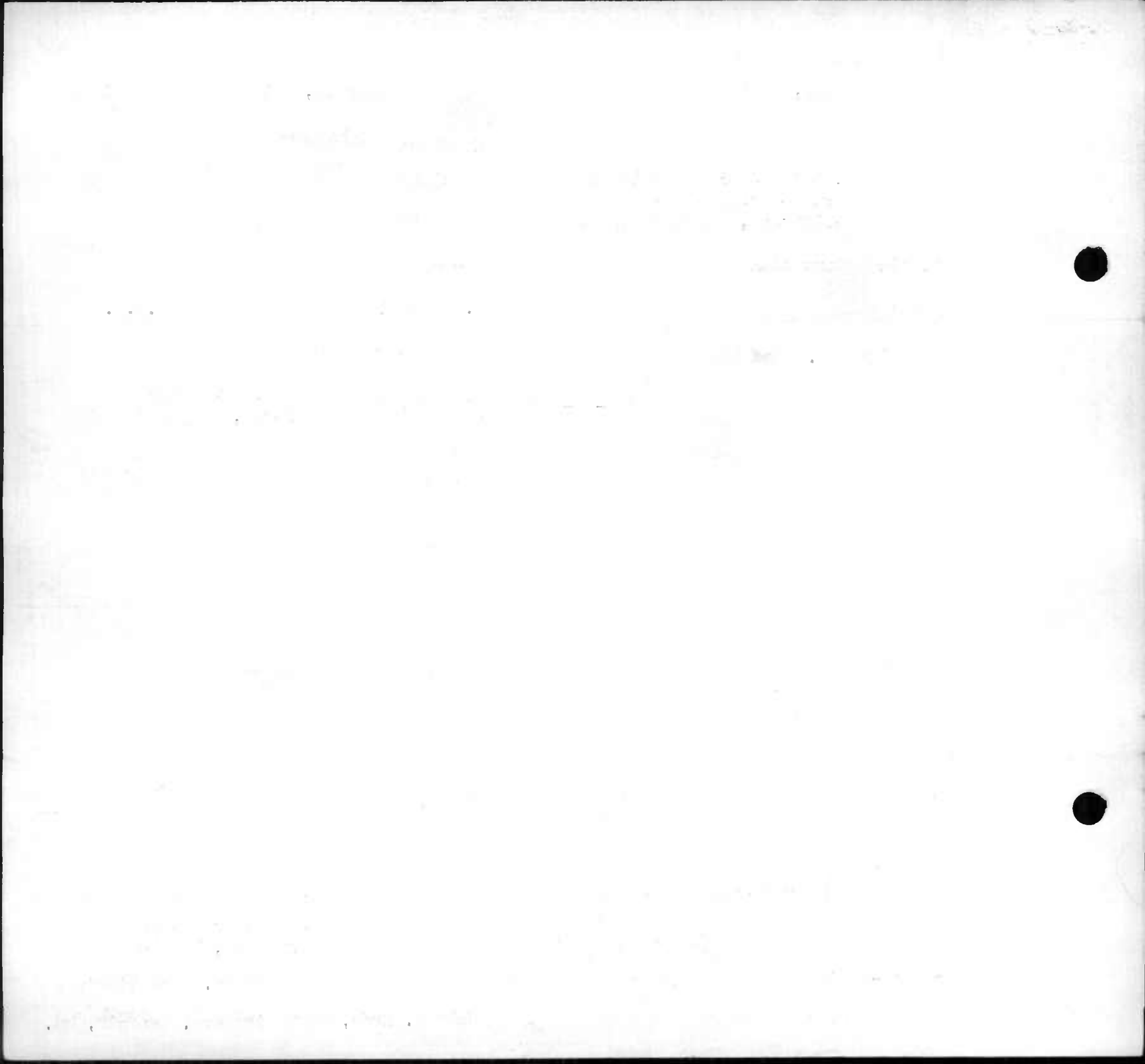
John J. Duda

ADDRESS

7922 Wise Ave. Dundalk, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

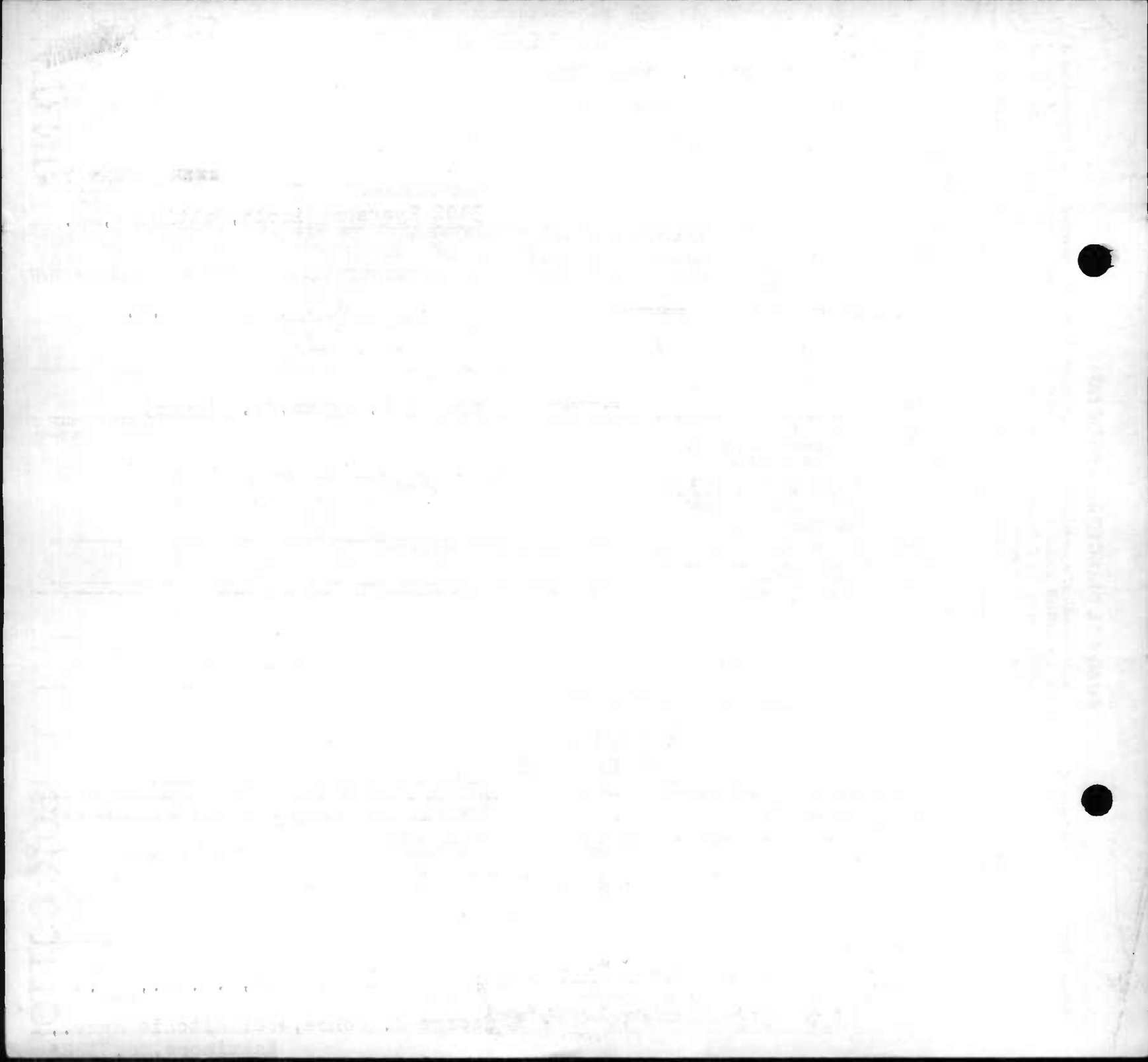
STATE OF MARYLAND - DEPARTMENT OF HEALTH CITY HEALTH DEPARTMENT				REG. NO. 72 06211	
BIRTH NO. 72-06211				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CHANEY, MARION C.			2. DATE AND HOUR OF DEATH June 27, 1972 5:02 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2533 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2204 1/2 Cedley Street		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7 5/16/19	9. AGE (In years last birthday) 53	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME THOMAS LEE CHANEY		
14. MOTHER'S MAIDEN NAME LILLIAN HOOPER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		
16. SOCIAL SECURITY NO. 216-22-4545			17. INFORMANT ADDRESS CLIN RCDS, VAH, BALTIMORE, MARYLAND		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E930.21 + 727.0 HEPATIC COMA IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: POSSIBLE SERUM HEPATITIS (Transfusion) 3-21-72 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slight rise in blood pressure UNDERLYING CONDITION last. II Collapsed Cervical Intervertebral disk			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 3-21-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cervical Spinal Fusion		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Loch Raven Veterans Hospital 19-02			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 3-21-72		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Blood transfusion during Surgery	
22. I certify that (X) (this hospital) attended the deceased from June 9, 1972 to June 27, 1972, that (X) (we) last saw the deceased alive on June 27, 1972 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Dean L. Vassar M.D.				23B. DATE SIGNED June 27, 1972	
23C. PHYSICIAN'S NAME (Type) DEAN L. VASSAR, M.D.				23D. ADDRESS VA HOSPITAL, BALTIMORE, MARYLAND 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/72		24C. NAME OF CEMETERY OR CREMATORY Western Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972			
25B. NAME OF REGISTRAR Audrey H. Weston		25C. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy, Baltimore, Maryland			

2/11/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

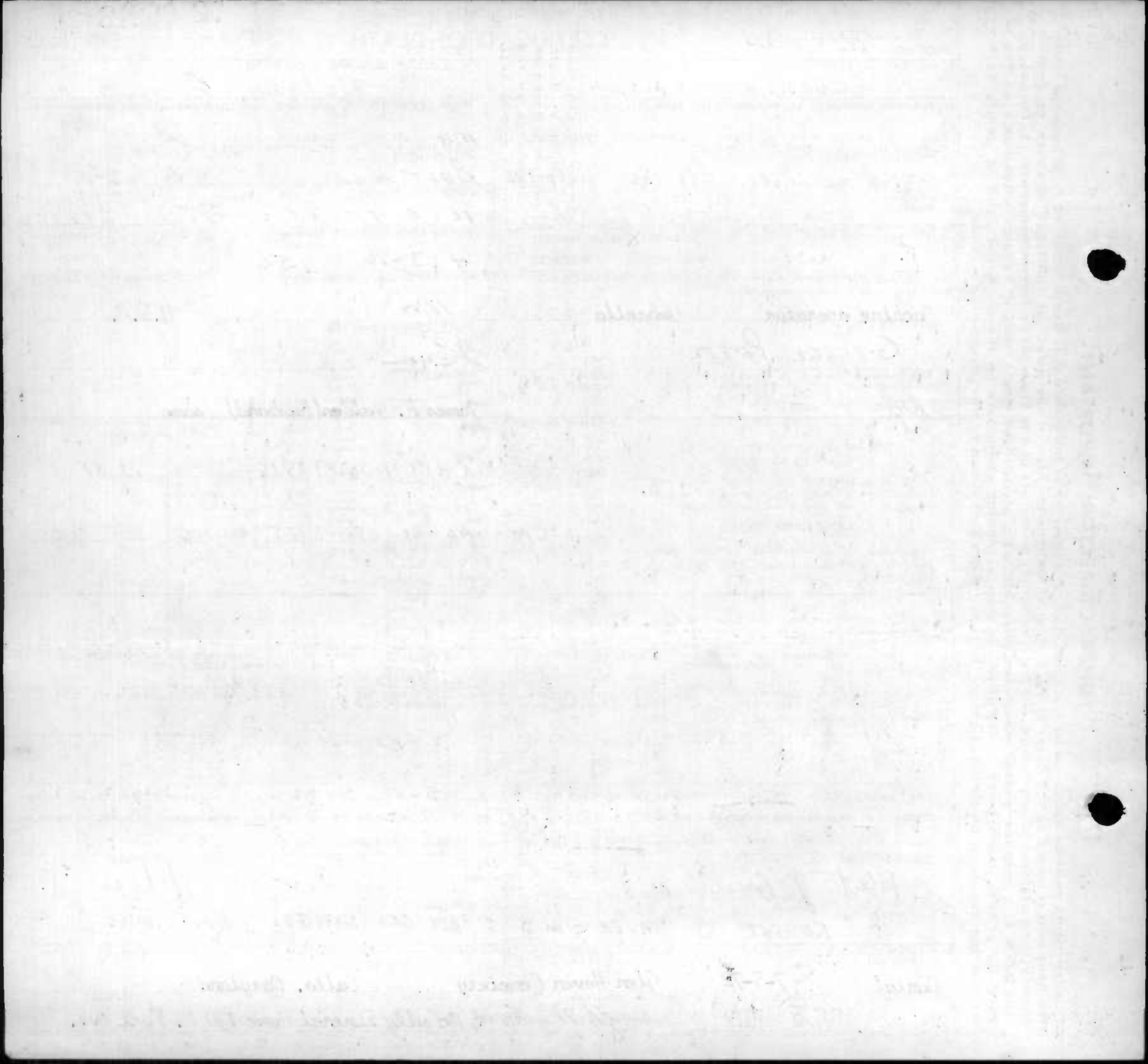
STATE OF MARYLAND-DHMH				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 06212</u>		9
BIRTH NO. <u>72-09132</u> <u>72 00212</u>				CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>Raymond B. Lyman 3rd</u> <u>BABY BOY LYMAN</u>				2. DATE AND HOUR OF DEATH <u>6-29-72</u> <u>8:40 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> <u>43</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> <u>Yes</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>3102 Ryerson Circle, Baltimore, Md.</u>		21227		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-72</u>	9. AGE (In years last birthday) <u>1</u>	10. UNDER 1 Yr. Months: <u>1</u> Days: <u>5</u>	11. UNDER 24 Hrs. Hours: <u>40</u> Min.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant= none</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>=====</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Raymond B Lyman Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Deborah Harris</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>=====</u>		17. INFORMANT <u>Raymond B. Lyman, Jr. (same)</u>			ADDRESS
18. <u>776.2. I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory distress syndrome</u> <u>c Prob. Congenital Heart disease</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory distress syndrome</u> <u>c Prob. Congenital Heart disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>29 hrs. 40 min.</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>=====</u>				
(C) DUE TO, OR AS A CONSEQUENCE OF: <u>=====</u>								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
19A. DATE OF OPERATION <u>6/29</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>=====</u>		20A. AUTOPSY? (Yes or No) <u>=====</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>=====</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>=====</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>=====</u>				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>=====</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>=====</u>				
22. I certify that (I) (this hospital) attended the deceased from <u>6/28</u> 19 <u>72</u> to <u>6/29</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6/29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE <u>Mayurce Rajadenuraks, M.D.</u>				23B. DATE SIGNED <u>6/29/72</u>				
23C. PHYSICIAN'S NAME (Type) <u>MAYURCE RATAJANURAKS, M.D.</u>				23D. ADDRESS <u>South Baltimore Gen. Hosp. Balt. Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, A.A.Co., Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Houston</u>		25C. FUNERAL DIRECTOR <u>George J. Gonce, 4001 Ritchie Hwy., Baltimore, Md. 21225</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

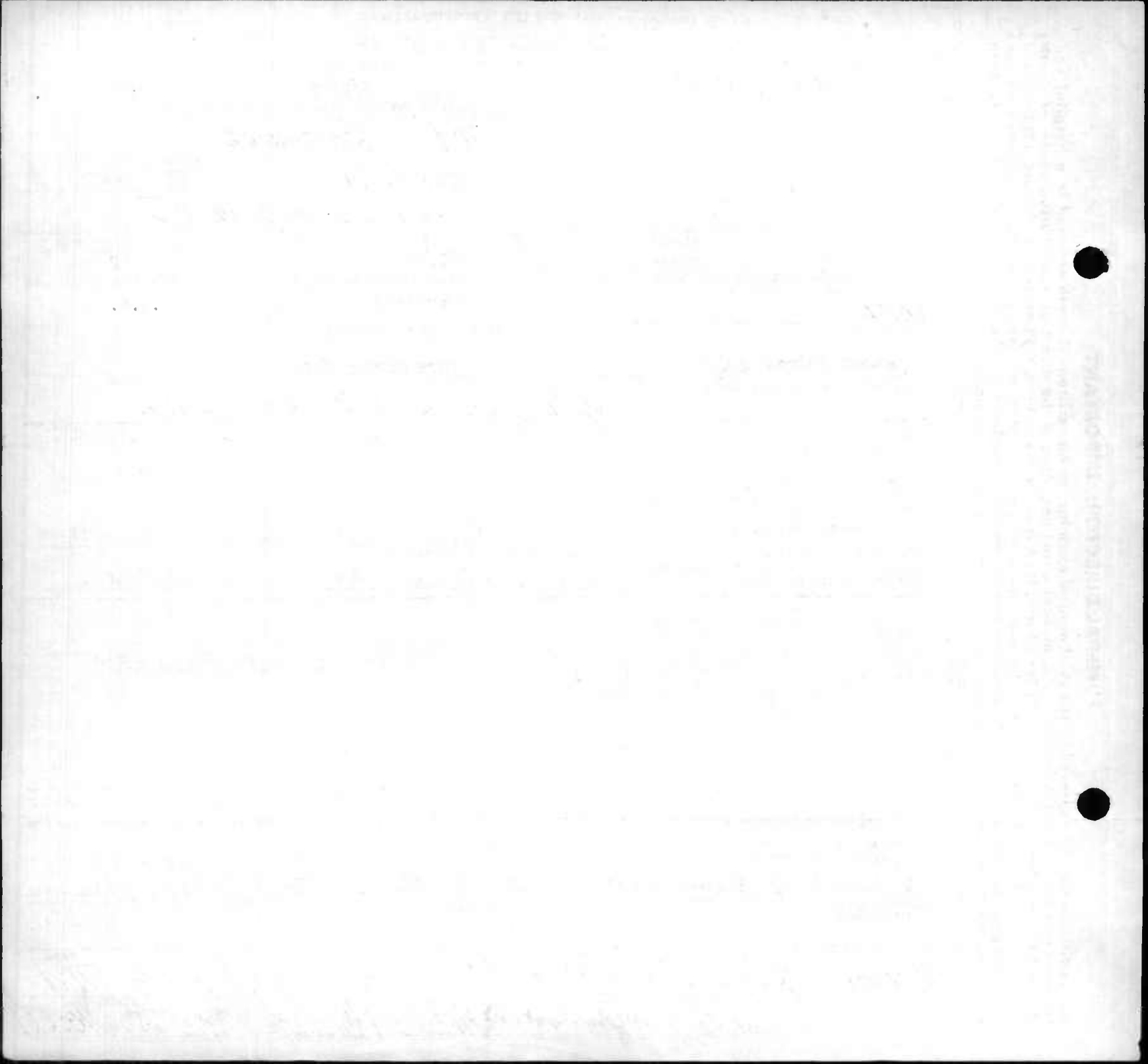
STATE OF MARYLAND - DEPARTMENT OF MARYLAND CITY HEALTH DEPARTMENT				72 06213	
BIRTH NO. 72 06213				REG. NO. 72 06213	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) ELEANOR WALDEN			2. DATE AND HOUR OF DEATH 7/2/72 3 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2302		
5. SEX F. 6. RACE W. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 4-3-16 9. AGE (In years last birthday) 56		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator			11. BIRTHPLACE (State or foreign country) MD.		
10B. KIND OF BUSINESS OR INDUSTRY Umbrella			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE POTEE			14. MOTHER'S MAIDEN NAME PEARL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. -		
17. INFORMANT James F. Walden (husband)			ADDRESS same		
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMATOSIS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR.		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA OF LEFT LUNG 2+ YRS.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 5 1972 to JULY 2 1972 , that (I) (we) last saw the deceased alive on JULY 2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert J. Bauer, M.D.				23B. DATE SIGNED 7/2/72	
23C. PHYSICIAN'S NAME (Type) ROBERT J. BAUER M.D.				23D. ADDRESS S. BALT. GEN. HOSPITAL, BALT., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-72		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) Balto. Maryland		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Andrew H. Heston		25C. FUNERAL DIRECTOR McGully Funeral Home 130 E. Fort Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DHMH		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. <u>72-06214</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Balko</u>		2. DATE AND HOUR OF DEATH <u>7/2/72</u> <u>2:00</u> <u>A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Parkville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1804 Dalhousie Ct</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/2/72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>2</u> If Under 1 Yr. Months: Days: Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Andrew Balko</u>		14. MOTHER'S MAIDEN NAME <u>Mary Martha Knott</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>James A. Balko same</u>
18. <u>743.81</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Arrest</u> (A) IMMEDIATE CAUSE <u>cardiorespiratory</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Immaturity of vital organs (CNS, lung)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Prematurity 29-30 weeks gestation</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>7/2/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>undercard catheterization</u>	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7/2/72</u> 19 <u>72</u> to <u>7/2</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/2/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Edmund S. Hemo MD</u>		23B. DATE SIGNED <u>7/2/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Edmund S. Hemo</u>		23D. ADDRESS <u>Wiedefeld Hemo 6500 York Rd</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/3/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick Rd Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>III 5 1972</u>		25B. NAME OF REGISTRAR <u>Audrey Hinton</u>	
25C. FUNERAL DIRECTOR <u>Wiedefeld Hemo</u>		25D. ADDRESS <u>6500 York Rd</u>	



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H-452

72 06215

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06215

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) STANLEY L. HOLMES, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 30, 1972 4:05 P. M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY HARVARD 6300	
7. RACE White		C. CITY OR TOWN Savage	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Jan 23, 1948		E. STREET AND NUMBER 413 Baltimore Street	
10. AGE (In years last birthday) 23 4 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF UNITED STATES		13. FATHER'S NAME Stanley L. Holmes (Dec)	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY none	
15. MOTHER'S MAIDEN NAME Blanche Hayes Gray		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Blanche M. Gray 7343 Bowie Road 20810 ADDRESS Laurel Md.	
19. E907X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Lighting (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Park		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Across from 1300 Blk. Tompkins Street, Brooklyn	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 6-30-72 3:30 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Struck by bolt of lighting		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/72	
24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Dorsey Road Wash Blvd Dorsey Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Audrey Johnston	
25C. FUNERAL DIRECTOR McCully Funeral Home		25D. ADDRESS 237 Patapaco Ave	

N9194.0 208003213

Stanley J. L. Holmes (ed)

Atlantic Ocean

Atlantic, July 1911

1911

WALTER

Sturtevant

Serial 7112

Geological Survey

Library of the United States

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STATE OF MARYLAND-DHMH
BALTIMORE CITY HEALTH DEPARTMENT

1
B-340

72 06216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH		72 06216	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) WILLIE LEE BATTLE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 SOUTH BALTO. GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour June 30, 1972 5:40 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2301			
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11-16-1935		10. AGE (In years lost birthday) 36 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clearance Howard		14. MOTHER'S MAIDEN NAME Sallie Bet	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 237-52-2282	
17. INFORMANT Mary Battle		18. ADDRESS 46 W. West Street	
19. 303.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Acute alcoholic intoxication (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 6/30/72 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Buairl		24B. DATE 7-5-72	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Sidney W. Houston	
25C. FUNERAL DIRECTOR I L Brown & Son		25D. ADDRESS 123 W. Montgomery	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Washington, D. C. 20535

TO : DIRECTOR, FBI (100-374302)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED]

RE: [REDACTED]

DATE: 10-1-68

CLASSIFICATION: [REDACTED]

100-374302-1000

100-100000-1000

100-100000-1000

100-100000-1000

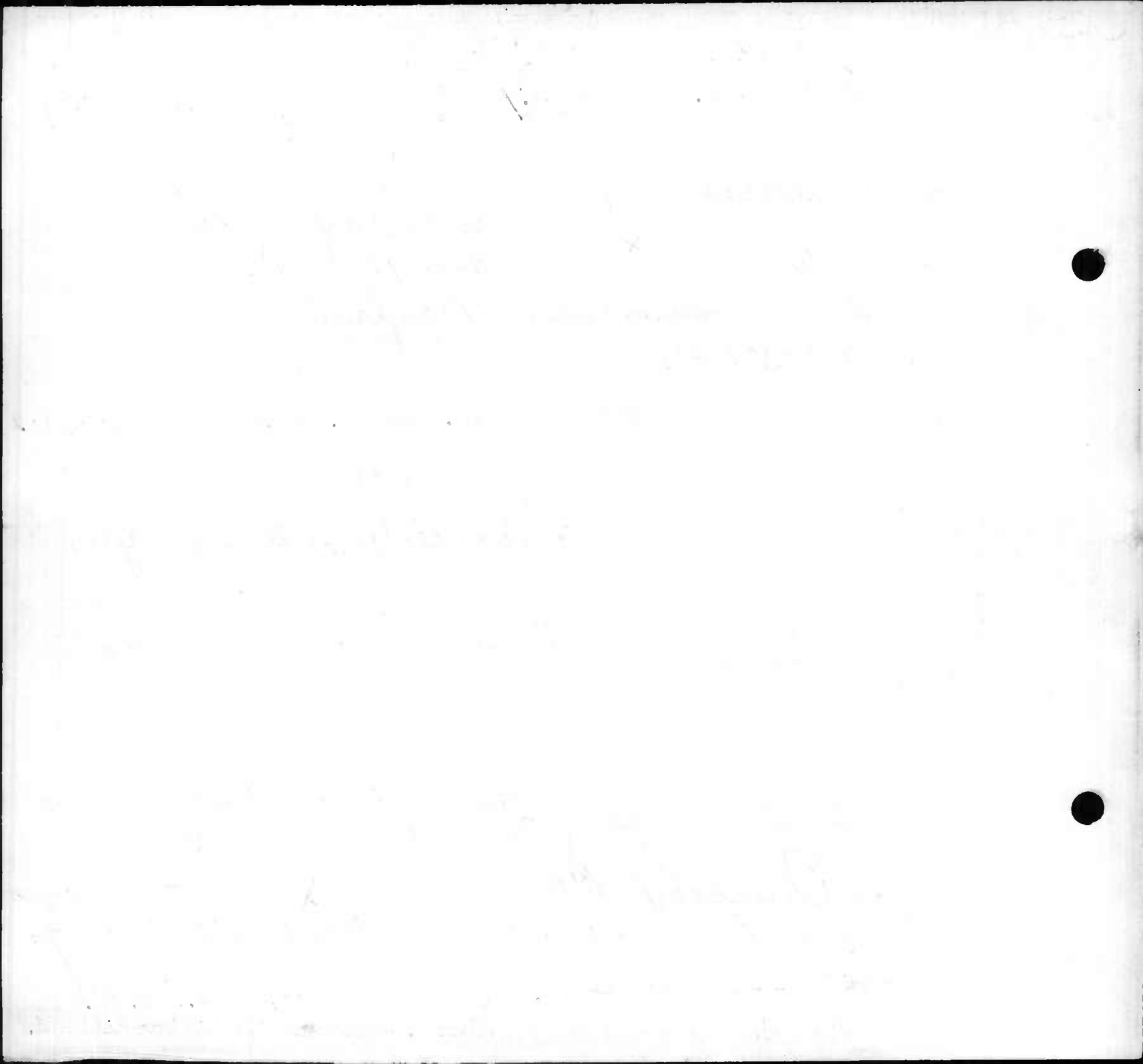
100-100000-1000

100-100000-1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEMO BALTIMORE CITY HEALTH DEPARTMENT																			
72 06217					CERTIFICATE OF DEATH					REG. NO. 72 06217									
1. NAME OF DECEASED (Type or Print) ARTHUR H. JONES Sr.										2. DATE AND HOUR OF DEATH July 2 1972 5:50 P.M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD North CHARLES Hosp.										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4017 Cold Spring Lane									
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19-92		9. AGE (In years last birthday) 80		10. If Under 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk										10B. KIND OF BUSINESS OR INDUSTRY Anderson & Ireland									
13. FATHER'S NAME HARRY JONES										14. MOTHER'S MAIDEN NAME ?									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no					16. SOCIAL SECURITY NO. 212 07 6506					17. INFORMANT Mrs. Myrtle E. Jones 4017 Cold Spring La.									
18. 437.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Recent yes Recent				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pneumonia																			
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from June 24 1972 to July 2 1972 that (I) (we) last saw the deceased alive on July 2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Ruperto Manankil M.D.										23B. DATE SIGNED 7-2-72									
23C. PHYSICIAN'S NAME (Type) Ruperto MANANKIL M.D.										23D. ADDRESS North CHARLES Gen. Hosp									
24A. BURIAL CREMATION, REMOVAL (Specify) burial					24B. DATE 7-5-72					24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem.					24D. LOCATION (City, town, or county) (State) Woodlawn, Balto., Co. Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972					25B. NAME OF REGISTRAR Sidney Johnston					25C. FUNERAL DIRECTOR John T. Stansbury 6411 Windsor Mill Rd.									

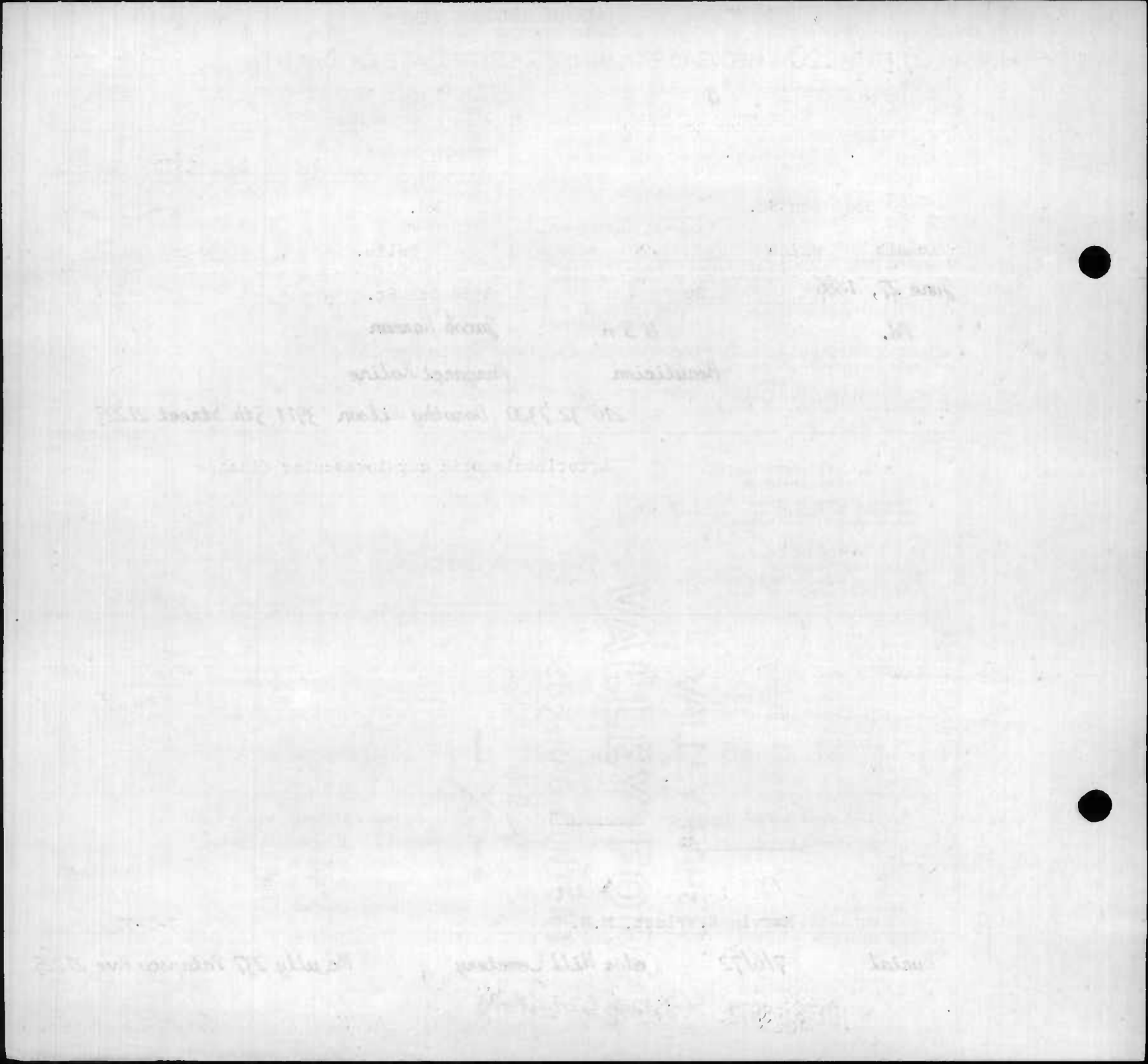


1
W-425

72 06218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 06218

BIRTH NO.

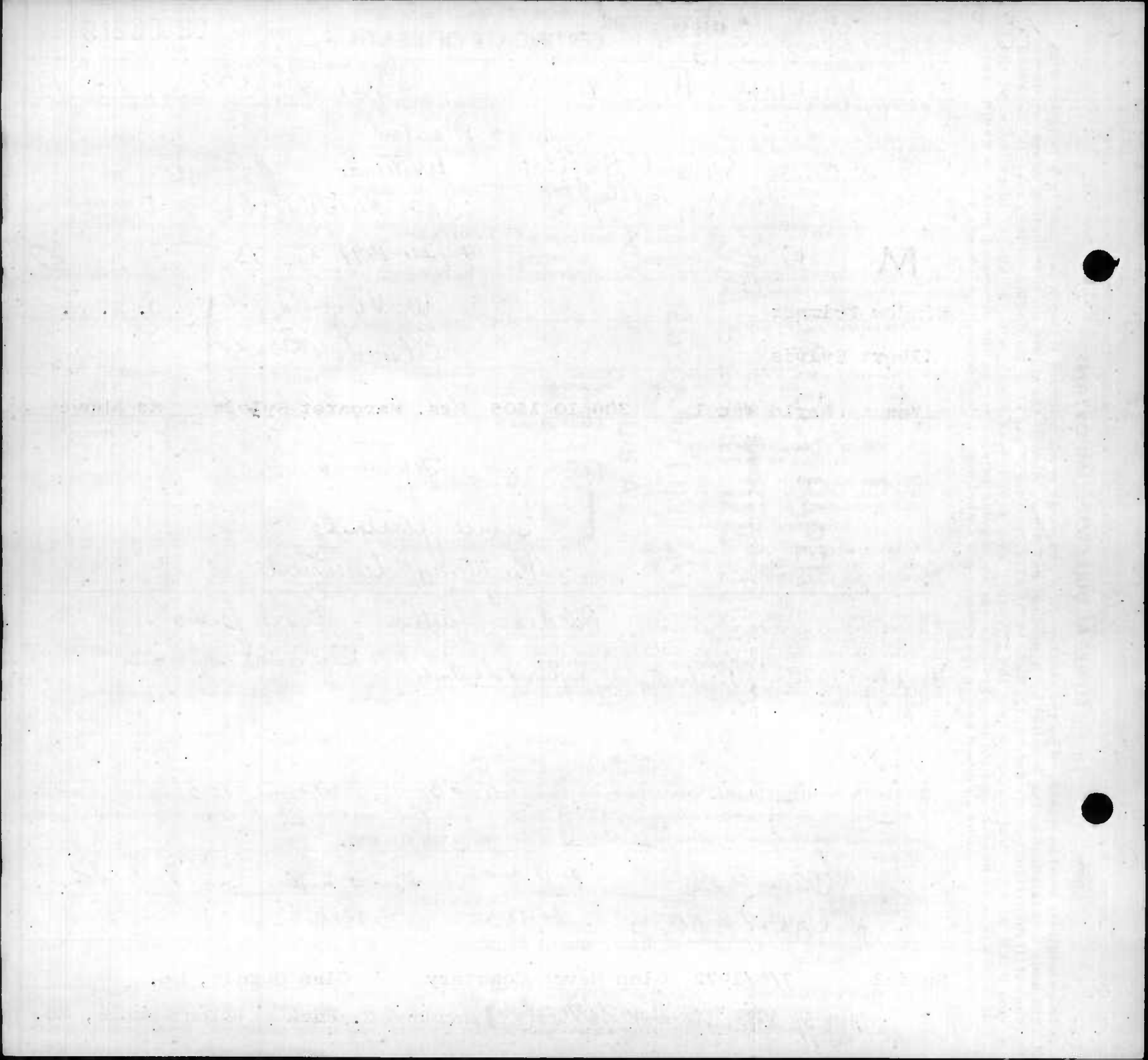
1. NAME OF DECEASED (Type or Print) JEANETT WILSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3556 6th St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 3 1972 10:55a M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2534	
9. DATE OF BIRTH June 27, 1886		10. AGE (In years lost birthday) 86 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF USA	
13. FATHER'S NAME Jacob Harman		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician	
15. MOTHER'S MAIDEN NAME Margaret Koline		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 216 32 7320		18. INFORMANT ADDRESS Dorothy Wilson 3911 5th Street 21225	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 7-3-72			
24A. BURIAL CREMATION, REMOVAL, (Specify) Burial		24B. DATE 7/6/72	
24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) McCully 237 Patapsco Ave 21225	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Andrew W. Houston	
25C. FUNERAL DIRECTOR McCully		25D. ADDRESS 237 Patapsco Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

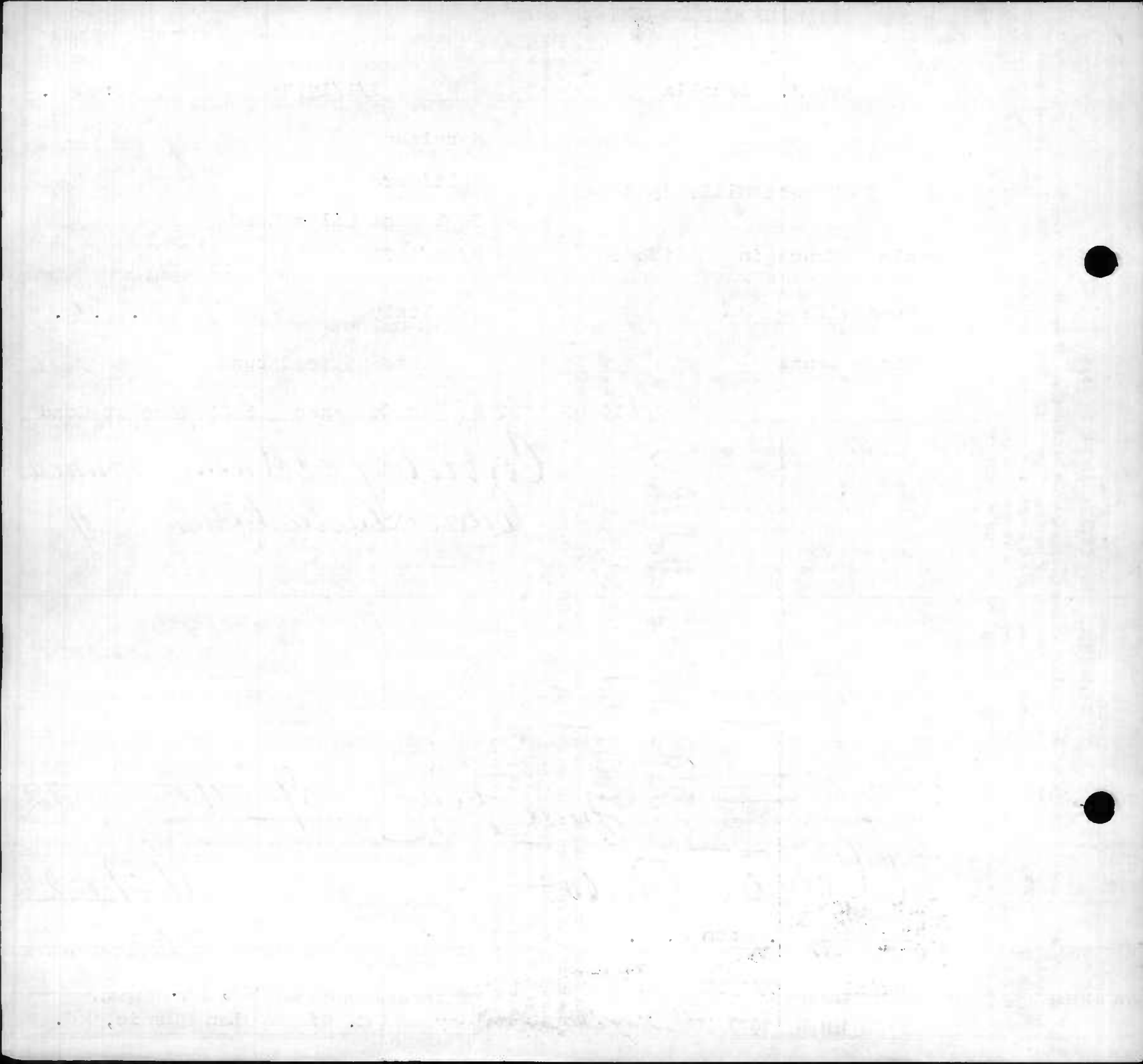
STATE OF MARYLAND-DHMH				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06219	
BIRTH NO. 72 06219						2. DATE AND HOUR OF DEATH JULY 3, 1972 7:25 P. M.			
1. NAME OF DECEASED (Type or Print) WILLIAM H. SYLVIS									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AA 5200			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) S. Baltimore General Hospital 3001 S. Haner, Balto. Md. 21230						C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 602 Nantuxer Av. NAUTILUS									
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-26-1897		9. AGE (In years last birthday) 75		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Trimmer				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Sylvis						14. MOTHER'S MAIDEN NAME Almeda Bruce			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War 1				16. SOCIAL SECURITY NO. 208 10 1505		17. INFORMANT Mrs. Margaret Sylvis		ADDRESS As Above	
18. 562.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION July 1, 1972 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Peritonitis 2° ruptured diverticuli 19C. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 6-23 1972 to 7-3 1972, that (I) (we) last saw the deceased alive on July 3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 23A. SIGNATURE R. Canzaro M.D. 23B. DATE SIGNED 7-3-72 23C. PHYSICIAN'S NAME (Type) R. CANZARO S M.D. 23D. ADDRESS 535 E 11 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 7/6/1972 24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. 25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972 25B. NAME OF REGISTRAR Sidney W. Weston 25C. FUNERAL DIRECTOR Raymond C. Fink ADDRESS Glen Burnie, Md.									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

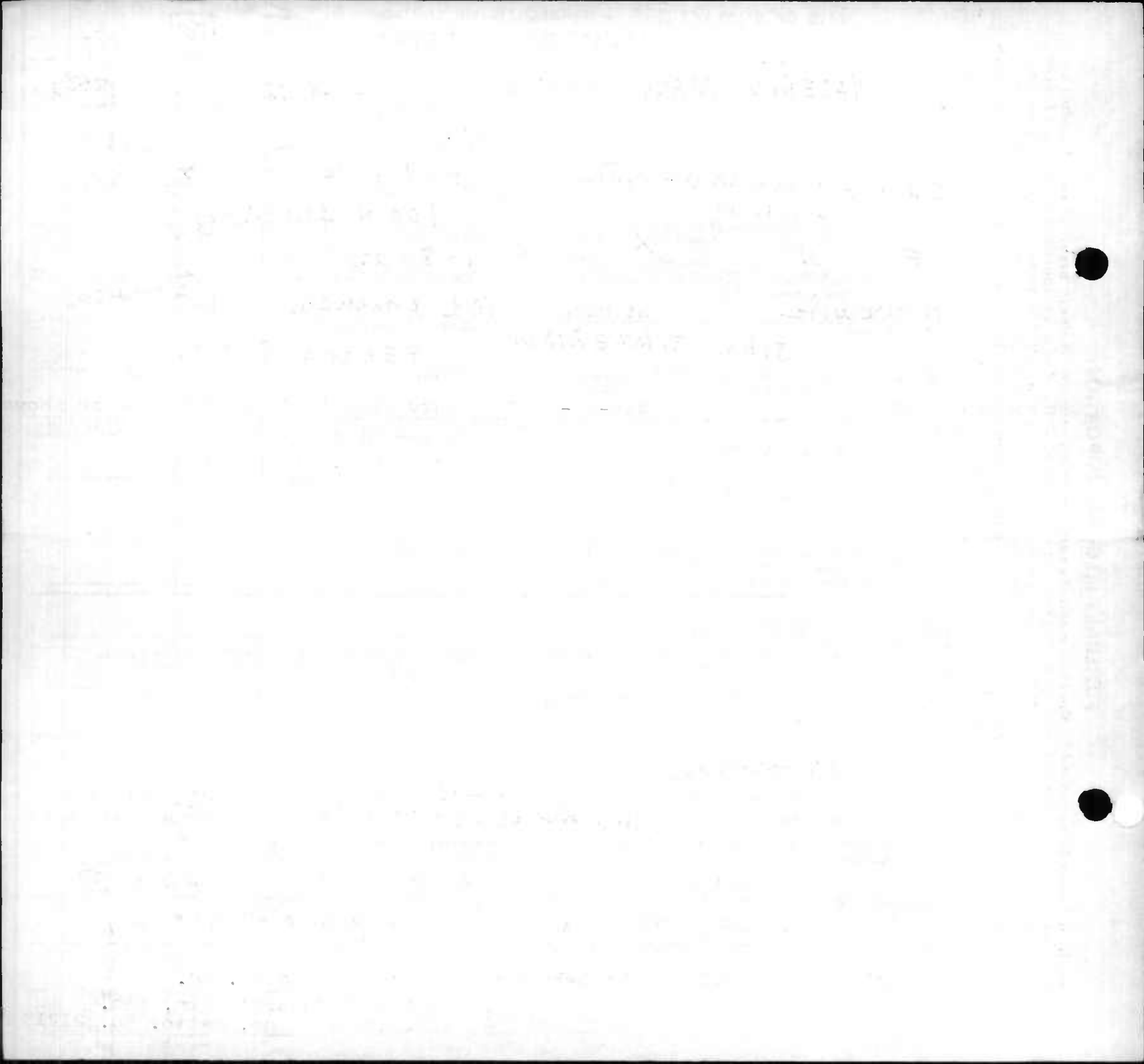
STATE OF MARYLAND - DEMO BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 72 00220	
BIRTH NO. 72 00220				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Eva J. Piscolla			
2. DATE AND HOUR OF DEATH		7/1/1972 11:40 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY Maryland 2834			
00 5002 West Hills Road		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5002 West Hills Road			
5. SEX Female	6. RACE Caucasin	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/16/1972	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Pardo Lanza		14. MOTHER'S MAIDEN NAME Antoinette Caruso	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216 03 0727 D		17. INFORMANT ADDRESS Ernie Basso 3623 Templar Road	
18. No 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Coronary occlusion immured. (B) DUE TO Anisochrotic h.t. dis. 57. (C) —		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 29, 1972 to 7/1, 1972, that (I) (we) last saw the deceased alive on June 29, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Christian S. Mass M. D.				23B. DATE SIGNED 7/3/72	
23C. PHYSICIAN'S NAME (Type) Christian S. Mass M. D.				23D. ADDRESS M.D. Howard County Medical Center	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/72		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 5 1972		24F. NAME OF REGISTRAR Aileen Johnston	
24G. FUNERAL DIRECTOR Raymond C. Fink		24H. ADDRESS Glen Burnie, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1/460 STATE OF MARYLAND - DEPT. OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06221	
BIRTH NO. 72 06221				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) VALERIO - MARY Catherine			2. DATE AND HOUR OF DEATH 6-28-72 350 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH Home and Hospital 100 N Broadway			A. STATE Md B. COUNTY 301		
5. SEX F 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			8. DATE OF BIRTH 1-8-22		9. AGE (In years last birthday) 50
10B. KIND OF BUSINESS OR INDUSTRY at home			11. BIRTHPLACE (State or foreign country) Md America		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME John TIMMERMAN			14. MOTHER'S MAIDEN NAME BERTHA PLITT		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-16-7704		17. INFORMANT Henry Valerio (husband)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 571.9 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cirrhosis of the Liver - Heart Failure, Respiratory Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 6-28-72 5:00 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-13-72 19 to 6-26-72 19 that (I) (we) last saw the deceased alive on 11 PM 6-26-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr Sajadi M.D. DEGREE				23B. DATE SIGNED 6-28-72	
23C. PHYSICIAN'S NAME (Type) DR - SAJADI M.D. DEGREE				23D. ADDRESS CHURCH Home and Hospital 100 N Broadway	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/72		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Balto. Md.		24E. NAME of REGISTRAR Sidney Houston		24F. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.	
24G. DATE REC'D BY HEALTH DEPT. JUL 5 1972		24H. ADDRESS 3331 Brehms Lane, Balto. Md. 21213			



1
C-450

STATE OF MARYLAND-DHMH BALTIMORE CITY HEALTH DEPARTMENT

72 06222

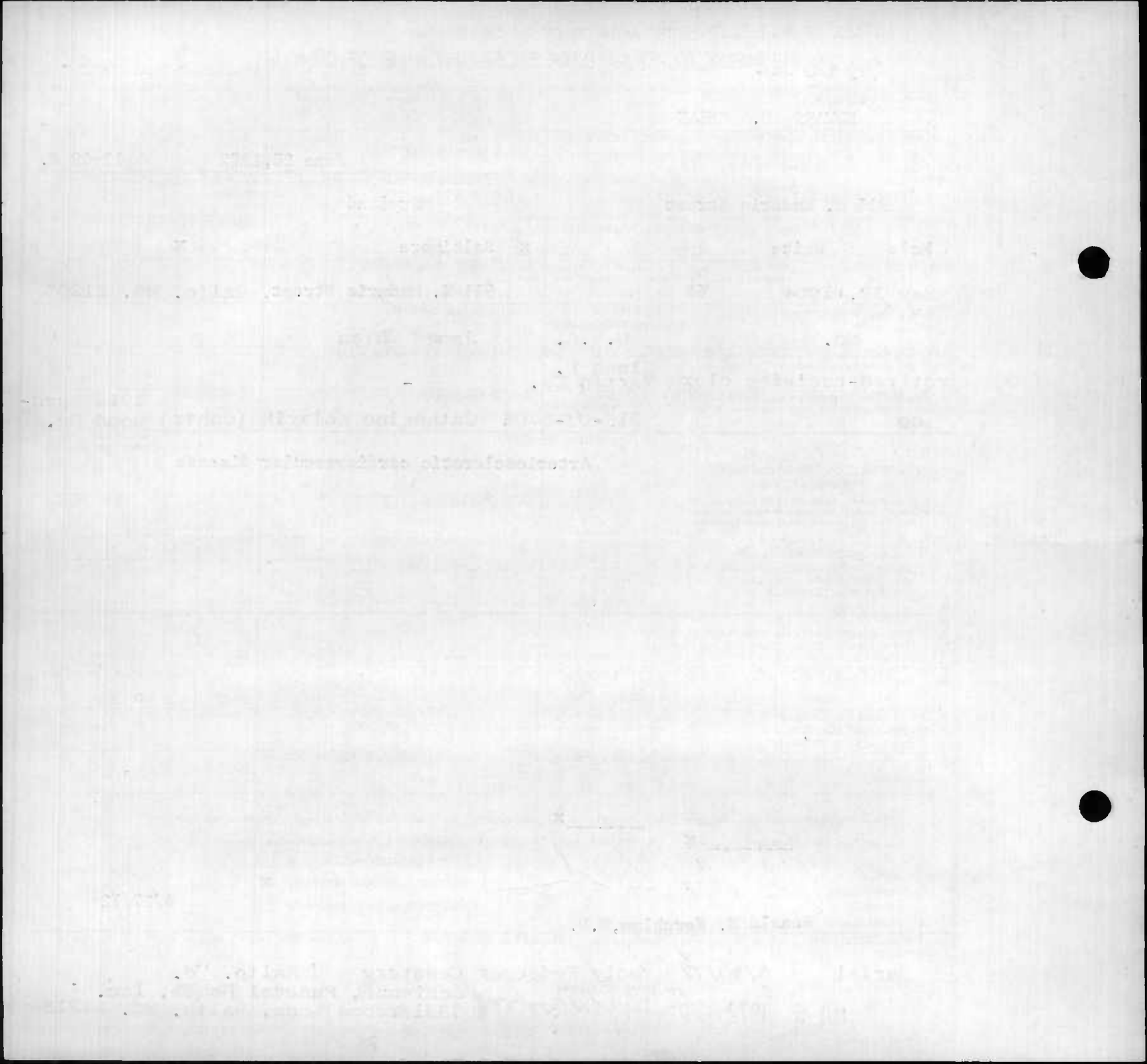
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 06222

BIRTH NO.

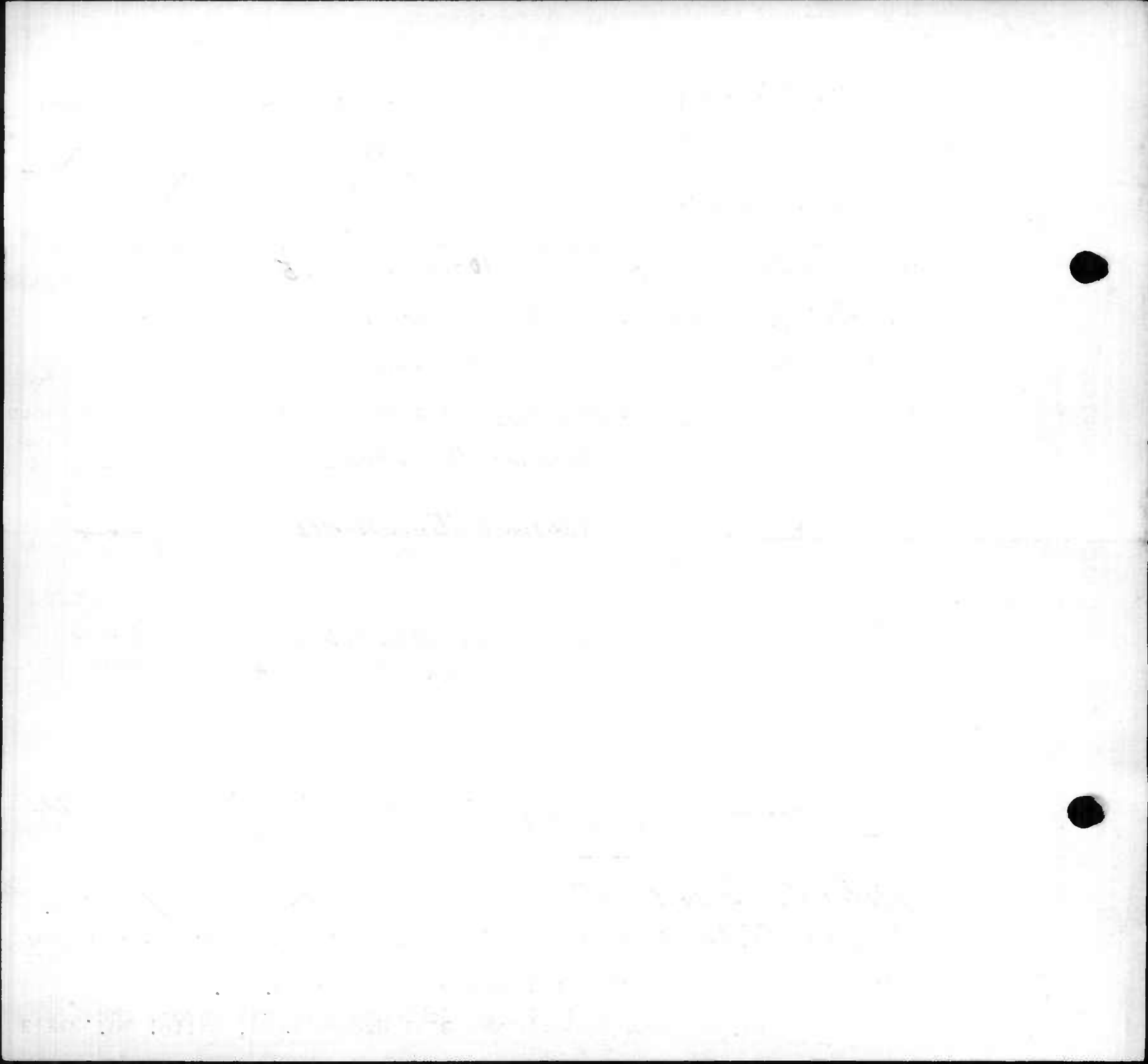
1. NAME OF DECEASED (Type or Print) EDWARD T. CHLAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 911 N. Maderia Street		3. DATE PRONOUNCED DEAD Month Day Year Hour June 27, 1972 12:19 P.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 703			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH May 30, 1904		10. AGE (In years lost birthday) 68	E. STREET AND NUMBER 911 N. Maderia Street, Balto. Md. 21205
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME James Chlan
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-rec'ving clerk		14B. KIND OF BUSINESS OR INDUSTRY Glenn L. Martin Co.	
15. MOTHER'S MAIDEN NAME -			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 213-03-6708	18. INFORMANT Catherine Kolarik (dghtr)
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.41 Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/27/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/72	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Audrey H. Houston	
25C. FUNERAL DIRECTOR Schlimmer Funeral Homes, Inc.		25D. ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

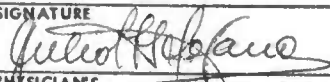

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DHMH		BALTIMORE CITY HEALTH DEPARTMENT	
L320 72 06223		REG. NO. 72 06223	
BIRTH NO. 72 06223			
1. NAME OF DECEASED (Type or Print) Anna Olga Ludwig		2. DATE AND HOUR OF DEATH 26 June 72 1:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Hospital		A. STATE Maryland B. COUNTY 702	
5. SEX F. 6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		8. DATE OF BIRTH 10-24-96	
10B. KIND OF BUSINESS OR INDUSTRY Southern Hotel		9. AGE (In years last birthday) 75	
13. FATHER'S NAME Unknown		11. BIRTHPLACE (State or foreign country) Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. 215-05-7498		14. MOTHER'S MAIDEN NAME Unknown	
17. INFORMANT Lawrence Ludwig (son)		ADDRESS same as above	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Central Thrombosis		months	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-18-72 to 7-26-72			
that (I) (we) last saw the deceased alive on 7-26-72			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John D. Talbert MD		23B. DATE SIGNED 26 June 72	
23C. PHYSICIAN'S NAME (Type) John D. Talbert MD		23D. ADDRESS 5601 Lock Room Blvd. Balto. 21239	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/72	
24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Sidney H. Weston	
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K613		STATE OF MARYLAND-DHMH		BALTIMORE CITY HEALTH DEPARTMENT		72 06224	
BIRTH NO. 72 06224		CERTIFICATE OF DEATH				REG. NO. 72 06224	
1. NAME OF DECEASED (Type or Print) KRAFT; MILDRED. C.				2. DATE AND HOUR OF DEATH 6-29-72 8:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3754 RAVENWOOD AVE. 21213			
5. SEX F	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03-02-09		9. AGE (In years last birthday) 63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME ANDREW LANGHIRT.			
14. MOTHER'S MAIDEN NAME Minnie ?				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No			
16. SOCIAL SECURITY NO. 212-09-9456				17. INFORMANT Mr. Andrew J. Kraft, Jr.			
18. ADDRESS (Same)				19. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Corruptive Heart Failure. DUE TO, OR AS A CONSEQUENCE OF:			
				(B) Chr. Renal Failure. DUE TO, OR AS A CONSEQUENCE OF:			
				(C) ASCVD.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-25-1972 to 6-29-1972 that (I) (we) last saw the deceased alive on 6-29-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED 6-29-72		23C. PHYSICIAN'S NAME (Type) Julio A. Dejo M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/72.		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md. 21234	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			

(1941)

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPT. BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 06225</u>	
BIRTH NO. <u>72 06225</u>				1. NAME OF DECEASED (Type or Print) <u>Brockmeyer, Margaret</u>		2. DATE AND HOUR OF DEATH <u>6-29-72 6:10 am</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u> <u>33rd and Calvert St.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Goled Canvalee Arum</u> 6116 <u>2734</u> B. COUNTY C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6116 Belair Road</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/21/1888</u> 8-21-1888	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13. FATHER'S NAME <u>Joseph Brockmeyer</u>			14. MOTHER'S MAIDEN NAME <u>Clara</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>214-14-5190</u>		17. INFORMANT <u>Mrs Guy Palmer</u> ADDRESS <u>phone no. NO8-9269</u>		
18. CAUSE OF DEATH <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6-18-72</u> 19 to <u>6-29-72</u> 19, that (I) (we) last saw the deceased alive on <u>6-29-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A. SHAHIDEH</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-29-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. SHAHIDEH, M.D.</u>				23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Heston</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		ADDRESS <u>Balto. Md.</u>	

Prev. Address 7/50 N.H.

3851/12/3
XXXXXX

21-1-1980

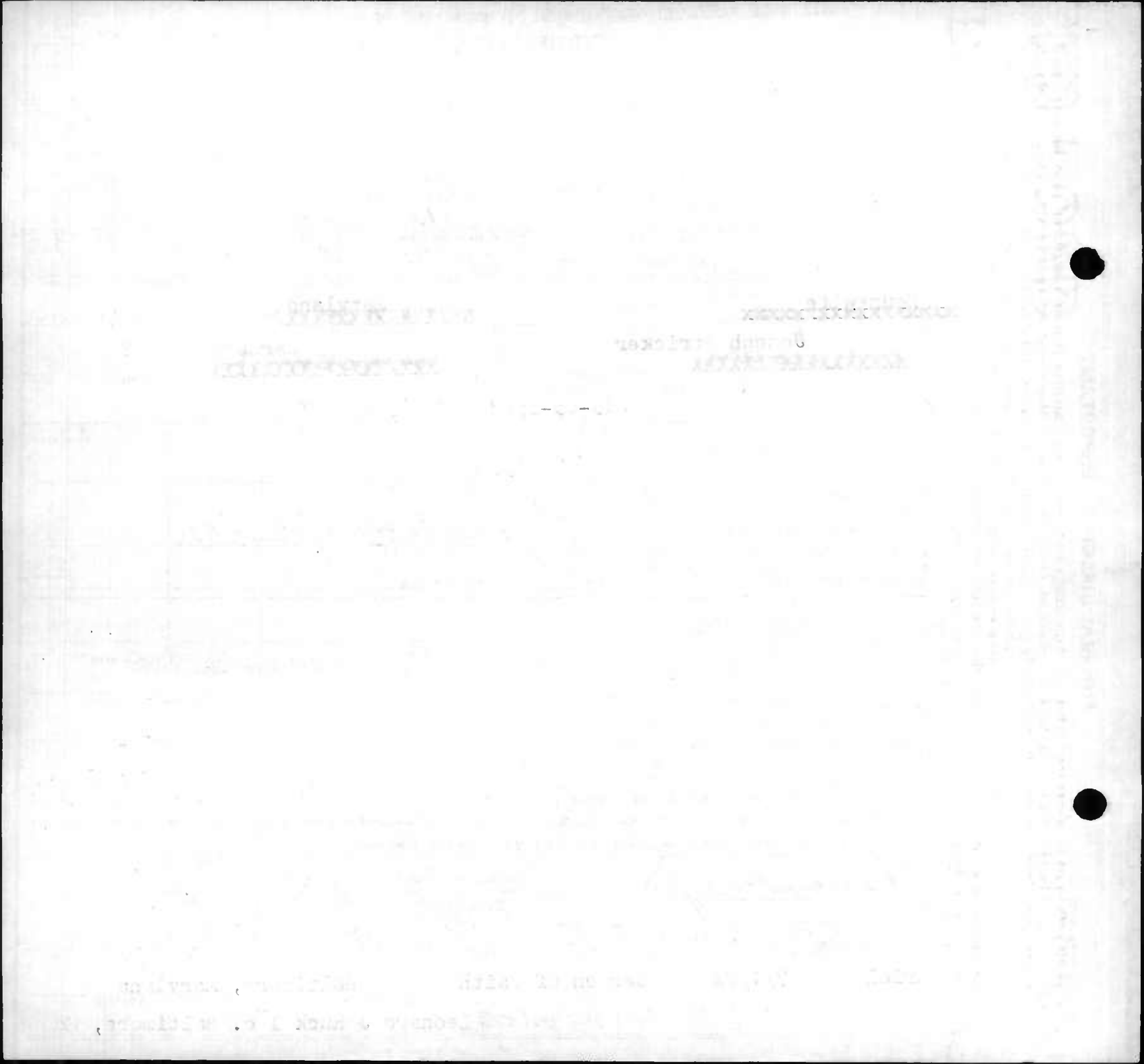
John Wiley & Sons, Inc.

1000 10th Ave. New York, N.Y. 10018

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

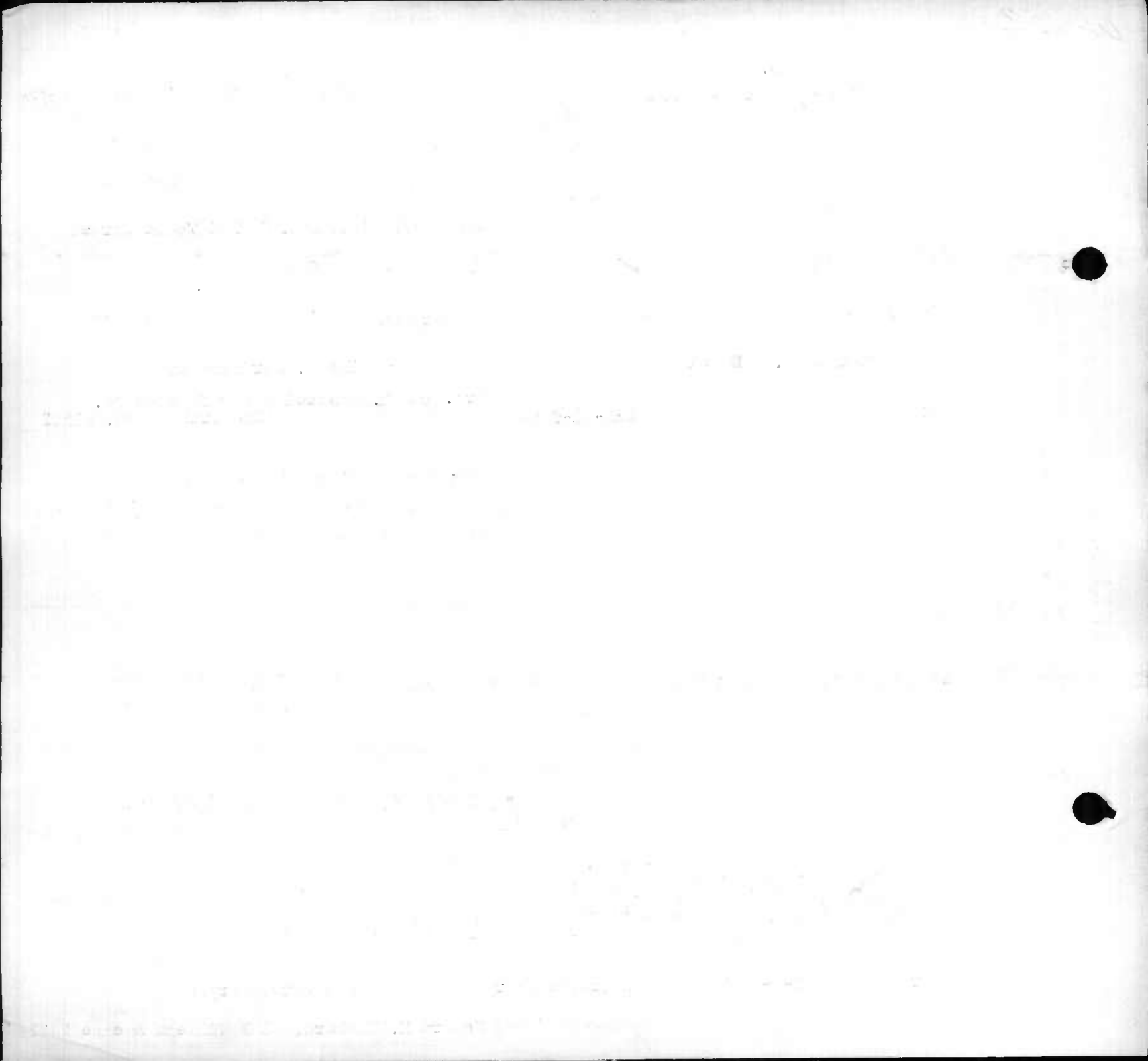
STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00226	
BIRTH NO. 72 00226				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SOPHIA TALBOTT		2. DATE AND HOUR OF DEATH 6/29/72 1245p			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 2641			
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER Todd Ave 5604			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-24-00	9. AGE in years (last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Joseph Stricker			
14. MOTHER'S MAIDEN NAME Barbara		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-05-3568		17. INFORMANT Chant			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Peritonitis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Perforation of colon		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 6/25/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Peritonitis		20A. AUTOPSY? (Yes or No) Askel.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 6/22/72 to 6/29/72 that (I) (we) last saw the deceased alive on 6/29/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cesar A. Alegria		23B. DATE SIGNED 6/29/72		23C. PHYSICIAN'S NAME (Type) CESAR A. ALEGRIA	
23D. ADDRESS The Union Memorial Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/1/72		24C. NAME OF CEMETERY or CREMATORY Garden Of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Sidney Indest		25C. FUNERAL DIRECTOR Leonard J. Ruck	
				ADDRESS c. Baltimore, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DEMH				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 00227</u>	
BIRTH NO. <u>72 00227</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mary Williams</u>				2. DATE AND HOUR OF DEATH <u>6/30/1972 at 4:50 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Md.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>md.</u> B. COUNTY <u>2636</u>			
5. SEX <u>F</u>		6. RACE <u>XV</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-5-04</u>	
9. AGE (in years last birthday) <u>67 yrs.</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
13. FATHER'S NAME <u>George W. Duvall</u>				14. MOTHER'S MAIDEN NAME <u>Ida B. Christopher</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-01-0896</u>		17. INFORMANT <u>Mrs. Ida M. Casteel</u> , 660 Fayette St. Cumberland, Md. 21502	
18. <u>444.41</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Malnutrition & dehydration</u> DUE TO, OR AS A CONSEQUENCE OF: <u>with secondary infection.</u> (B) <u>Arterial occlusion of leg</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>6/6/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gangrene of lower limb</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/28/72</u> 19 to <u>6/30/72</u> 19 that (I) (we) last saw the deceased alive on <u>6/30/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dr. Penkar</u>				23B. DATE SIGNED <u>6/30/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. PENKAR</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-3-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Winston</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u> , 4107 Wilkens Avenue 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-420 72 06228 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 72 06228

BIRTH NO. STATE OF MARYLAND-DEME

1. NAME OF DECEASED (Type or Print) Moses Wells 2. DATE AND HOUR OF DEATH July 3, 1972 2 25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Harbor View Nursing Home 1213 Light St S A. STATE Md. B. COUNTY Anne Arundel C. CITY OR TOWN Annapolis D. INSIDE CITY LIMITS? YES ☐ NO ☒ E. STREET AND NUMBER Rt. 2 Bldg 121 Edgewater

5. SEX Male 6. RACE Col. African 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 7/22/96 9. AGE (in years last birthday) 75 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Moses Wells 14. MOTHER'S MAIDEN NAME Alice Spriggs 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Annie Wells - Edgewater ADDRESS Rt. 2 Bldg 121

18. 185X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE CA of Prostate DUE TO, OR AS A CONSEQUENCE OF: Metastasis to Bone (B) DUE TO, OR AS A CONSEQUENCE OF: (C) AS-C-V-D

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

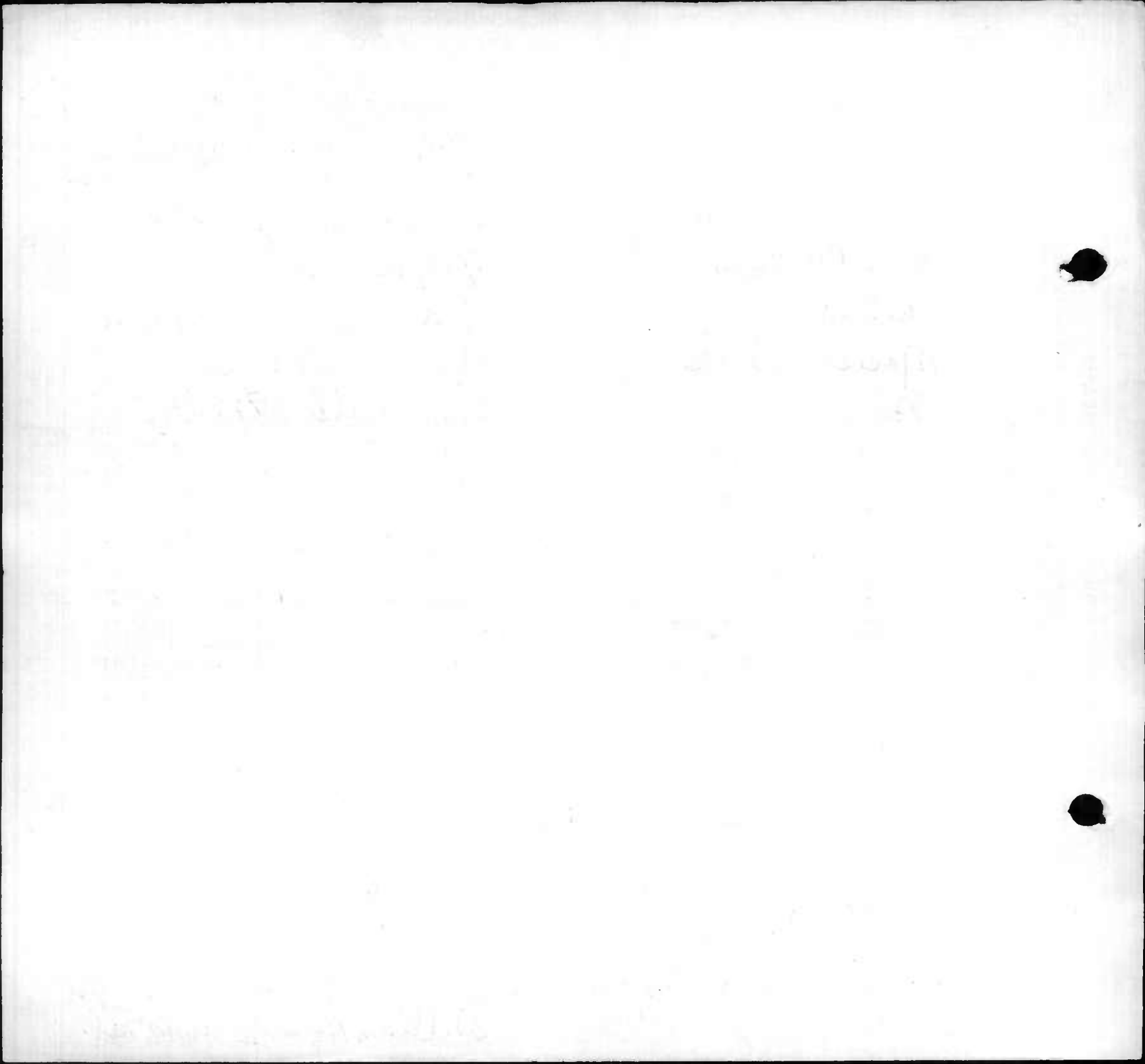
22. I certify that (I) (this hospital) attended the deceased from MAY 12 19 72 to 7/3 19 72 that (I) (we) last saw the deceased alive on 6/8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Joseph S. Blum 23B. DATE SIGNED 7/5/72 23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM 23D. ADDRESS 1115 N CALVERT ST

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 7/6/72 24C. NAME OF CEMETERY OR CREMATORY Stopes Chapel 24D. LOCATION (City, town, or county) Edgewater A.A. Md.

25A. DATE REC'D BY HEALTH DEPT JUL 5 1972 25B. NAME OF REGISTRAR William Reese II - Annapolis Md. 25C. FUNERAL DIRECTOR ADDRESS

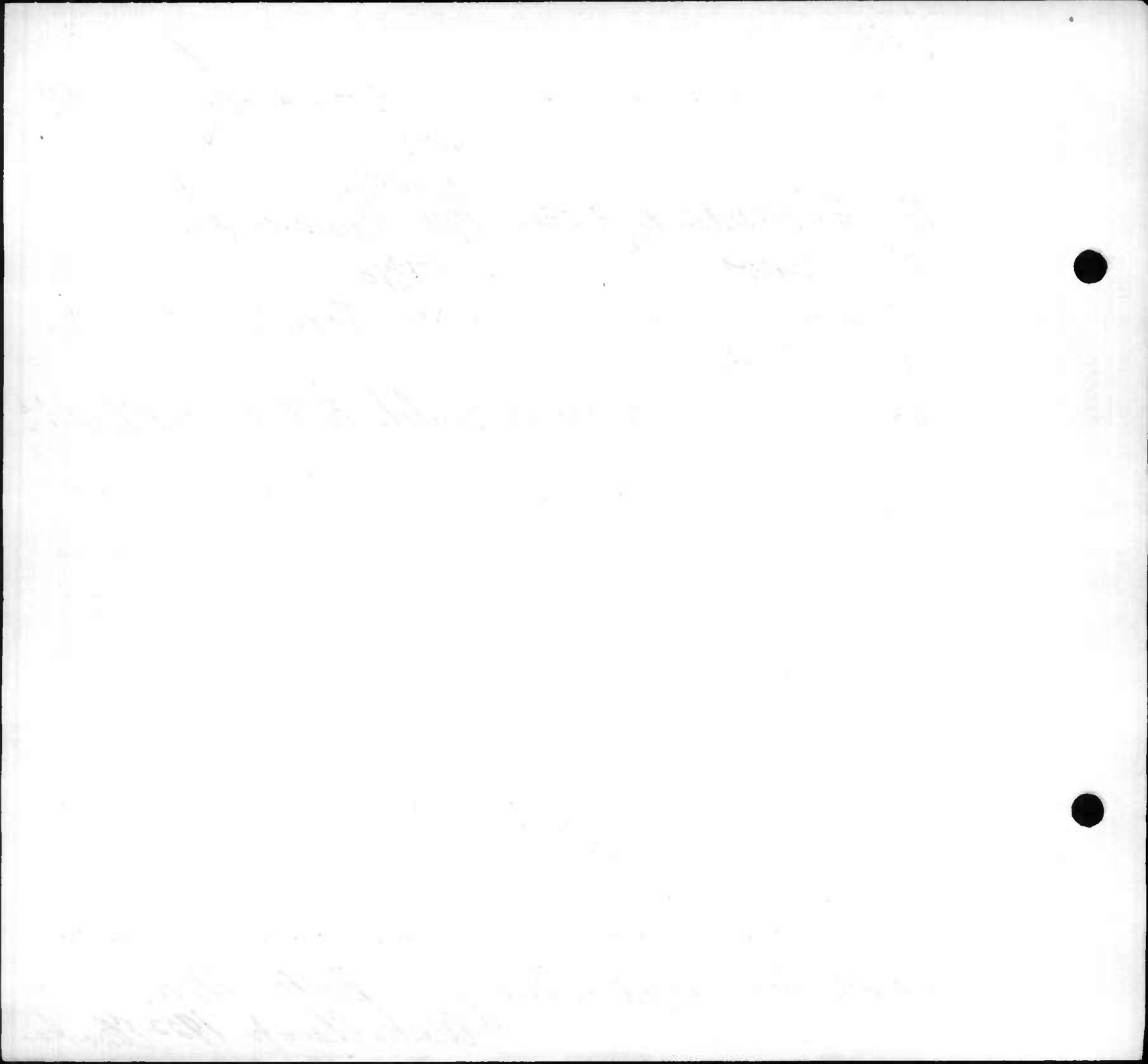
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

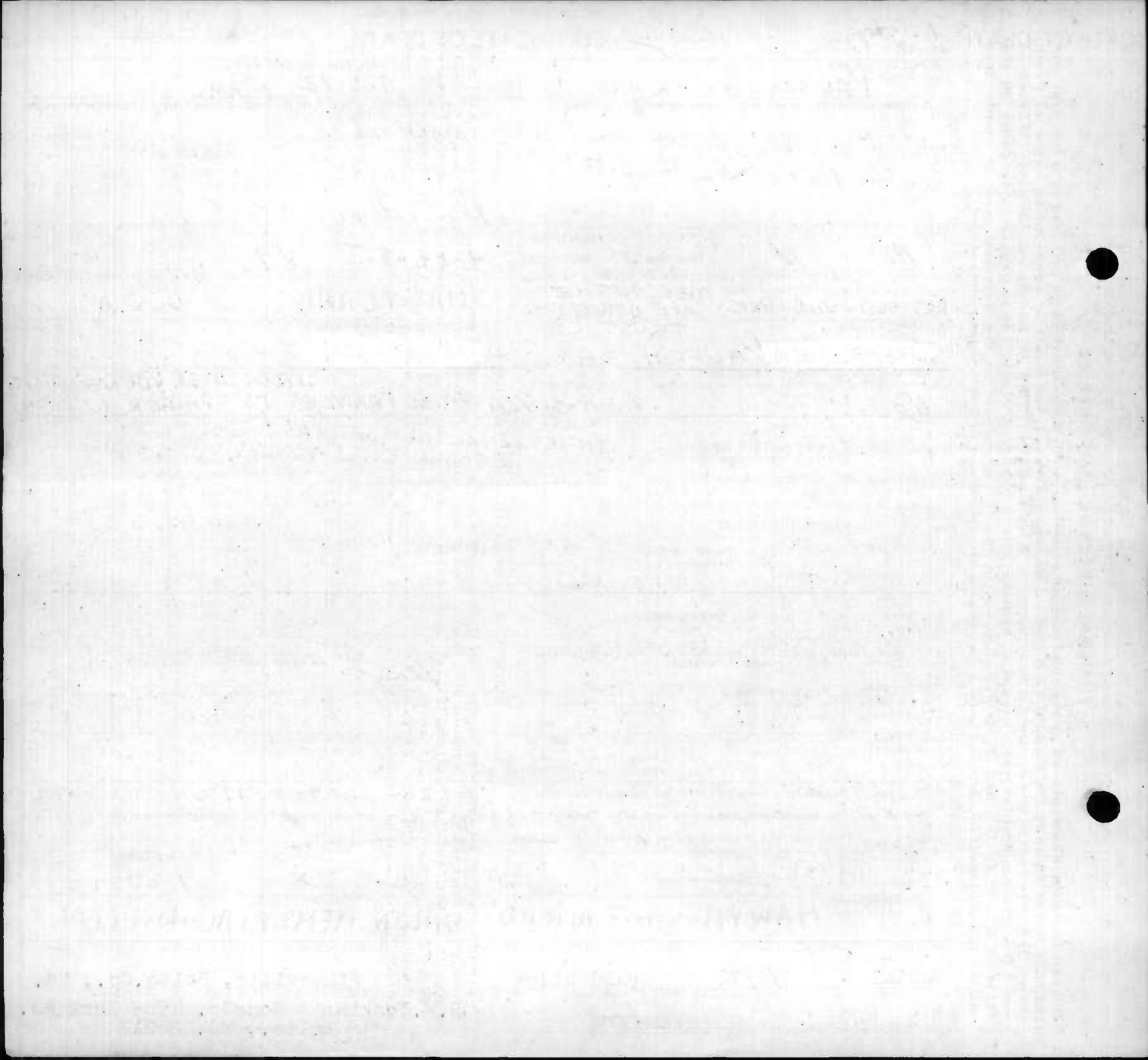
STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT				72 06229	
CERTIFICATE OF DEATH				REG. NO. 72 06229	
BIRTH NO. <u>H-408</u>				DATE AND HOUR OF DEATH <u>6-24-72 7:30 PM</u> M.	
1. NAME OF DECEASED (Type or Print) <u>CRUSH HOLLOWAY</u>				2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1604</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1916 Edmondson Ave.</u>				C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>9-15-1896</u> 9. AGE (in years last birthday) <u>75</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Tailor shop</u>	
11. BIRTHPLACE (State or foreign country) <u>WACO TEXAS</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thom Holloway</u>				14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-01-6058</u>	
17. INFORMANT <u>Bessie Holloway</u>				ADDRESS <u>1916 Edmondson Ave</u>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ca of the Lung</u>				<u>9 months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 5</u> 19 <u>72</u> to <u>May 17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>May 17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Roland T. Smoot</u> DEGREE				23B. DATE SIGNED <u>6/28/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROLAND T. SMOOT, M. D.</u> DEGREE				23D. ADDRESS <u>2300 Garrison Boulevard Balto., Md. 21216</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6-29-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Harrison</u>		25C. FUNERAL DIRECTOR <u>Wesley Chavis</u> ADDRESS <u>1922 Edmondson</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-200-72 06230		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06230	
BIRTH NO. 72 06230		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PAUSCH, George		2. DATE AND HOUR OF DEATH 7-2-72 1 PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1202			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION Memorial Hospital 44		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 209 Southway 21218					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-05-85	9. AGE (In years last birthday) 87	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - VICE-PRES
10B. KIND OF BUSINESS, OR INDUSTRY MERCANTILE SAFE DEPOSIT X		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME TRUST CO. GEORGE PAUSCH, SR.		14. MOTHER'S MAIDEN NAME MARY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-3846A		17. INFORMANT ADDRESS 1261 MERIDENE DRIVE MISS FRANCES D. SPAMER (21239)	
18. 569.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6/28 1972 to 7/2 1972, that (we) last saw the deceased alive on the second of July 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Shocair		23B. DATE SIGNED 7.2.1972			
23C. PHYSICIAN'S NAME (Type) MAWYA SHOCAIR MD		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/72		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto., Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1972		25B. NAME OF REGISTRAR Sidney L. Johnson		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	



Approved by Medical Examiner
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>K-550</u>		72 00231		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 00231</u>	
BIRTH NO. STATE OF MARYLAND - <u>DEATH</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Edward B. Kohnen</u>				2. DATE AND HOUR OF DEATH <u>7/3/72</u> <u>3:30 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Long Green Nursing Home</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1307</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Long Green Nursing Home</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>Wyman Park Apts.</u>							
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/21/1893</u>	
9. AGE (In years last birthday) <u>79</u>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AST. UNDEL CORP.</u>		11. BIRTHPLACE (State or foreign country) <u>Irving, New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Nicholas Kohnen</u>		14. MOTHER'S MAIDEN NAME <u>Corine Feidholm</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>255-01-4934</u>		17. INFORMANT <u>Miss Billie Snead</u>		ADDRESS <u>(Same)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congestive heart failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic heart disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Fractured hip, rt.</u> (C) <u>1 mo.</u> <u>5 yrs.</u> <u>1 mo.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>5 yrs.</u> <u>1 mo.</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE IMMEDIATE DISEASE OR CONDITION GIVEN IN PART 18 <u>None - Condition did not warrant operation</u>				20A. AUTOPSY? (Yes or No) <u>None</u>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? <u>Wyman Park Apt.</u>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <u>6/4/72 - 10 PM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fall when confused</u>			
22. I certify that (1) <u>(the hospital)</u> attended the deceased from <u>7/3</u> 19 <u>53</u> to <u>7/3</u> 19 <u>72</u> that (1) <u>lost</u> saw the deceased alive on <u>6/27</u> 19 <u>72</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>(We did not)</u> view the body after death.							
23A. SIGNATURE <u>Norman J. Freeman, Jr.</u>				23B. DATE SIGNED <u>7/3/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Norman J. Freeman, Jr., M.D.</u>				23D. ADDRESS <u>11 W. 29th Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Rem. Burial</u>		24B. DATE <u>7/5/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Barbourville City Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Barbourville, Ky.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1972</u>		25B. NAME OF REGISTRAR <u>Sidney B. Johnson</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Road Balto., Md. 21212</u>	

3955 BEECH AVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				72 00232 REG. NO.	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Margaret Arnold</i>		2. DATE AND HOUR OF DEATH <i>6/29/1972 2:25 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lutheran Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1604</i> C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>4615 Park Heights Pleasant Manor</i>			
5. SEX <i>F</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/3/04</i>	9. AGE (in years last birthday) <i>78</i>	11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemployed</i>		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Arnold</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Calbert</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-12-5961</i>		17. INFORMANT <i>S</i> ADDRESS <i>Mrs. Lois M. Moore 4003 Fernhill Avenue</i>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <i>Nephrosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Uraemia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/19/1972</i> to <i>6/29/1972</i> that (I) (we) last saw the deceased alive on <i>6/29/1972</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>D. S. Kar Bhari</i>				23B. DATE SIGNED <i>6/29/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>D. S. KAR BHARI</i>				23D. ADDRESS <i>Lutheran Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-3-72</i>		24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill</i>	
24D. LOCATION (City, town, or county) (State) <i>A. A. Co., Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1972</i>			
25B. NAME OF REGISTRAR <i>Frederick Johnson</i>		25C. FUNERAL DIRECTOR <i>Arlington S. Phillips 1727 N. Monroe Street</i>			

1905 Edmondson Ave. - Prev. Address

2/24/72 - Adm.

X

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72-06233</u>	
B-650 72 06233 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>WILLIAM BROWN</u>			2. DATE AND HOUR OF DEATH <u>JULY 2 1972 11:08:15 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2408 E. LAFAYETTE</u>		
5. SEX <u>M</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04/07/14</u>	9. AGE (In years last birthday) <u>58</u>	10. If Under 1 Yr. Months; Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIP CREWMAN</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>Brown, William</u>		
14. MOTHER'S MAIDEN NAME <u>Adams, Elsie</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>717-07-7144</u>			17. INFORMANT <u>ELsie BROWN</u> ADDRESS <u>2408 E. LAFAYETTE AVE. BALT. MD.</u>		
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIORESPIRATORY ARREST</u>				<u>Shro.</u>	
(B) <u>OVERWHELMING PNEUMONIA, ? TUBERCULOSIS</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>2 days</u>	
(C) <u>POSSIBLE METASTASES FROM ESOPHAGEAL CA</u>				<u>3 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>DEHYDRATION + MALNUTRITION</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4:00 AM JULY 1 1972</u> to <u>10:15 AM JULY 2 1972</u> that (I) (we) lost saw the deceased alive on <u>JULY 2 1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frederick L. Ferris III MD</u> DEGREE				23B. DATE SIGNED <u>July 2, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>FREDERICK L. FERRIS III MD</u> DEGREE				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/7/72</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. CALVARY CEMETARY</u>	
24D. LOCATION (City, town, or county) <u>ANNE ARUNDEL CO. MD.</u>		24E. (State)			
25A. DATE RECD BY HEALTH DEPT. <u>JUL 5 1972</u>		25B. NAME OF REGISTRAR <u>Frederick L. Ferris III</u>		25C. FUNERAL DIRECTOR <u>WILLIAM J. SPICER</u> ADDRESS <u>1639 N. BROADWAY BALT. MD.</u>	

Adams, Elsie

Reynolds, William

1852

M-600

72 06237

BALTIMORE CITY HEALTH DEPARTMENT

72 06237

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DHMH

REG. NO.

1. NAME OF DECEASED (Type or Print) MILTON MOORE				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2226 Madison Avenue				3. DATE PRONOUNCED DEAD Month Day Year July 3, 1972 Hour 11:50 P.			
6. SEX Male				7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4-28-28				10. AGE (In years last birthday) 44		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Theodore R. Moore		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW2				16. SOCIAL SECURITY NO. 084 22 8005		17. INFORMANT Elsie Moore	
18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				19. CAUSE OF DEATH Hypertensive cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) no				22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/4/72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-8-72			
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972				25B. NAME OF REGISTRAR Lewis T. Gwynn			
25C. FUNERAL DIRECTOR Lewis T. Gwynn				25D. ADDRESS 4517 Park Heights Ave.			

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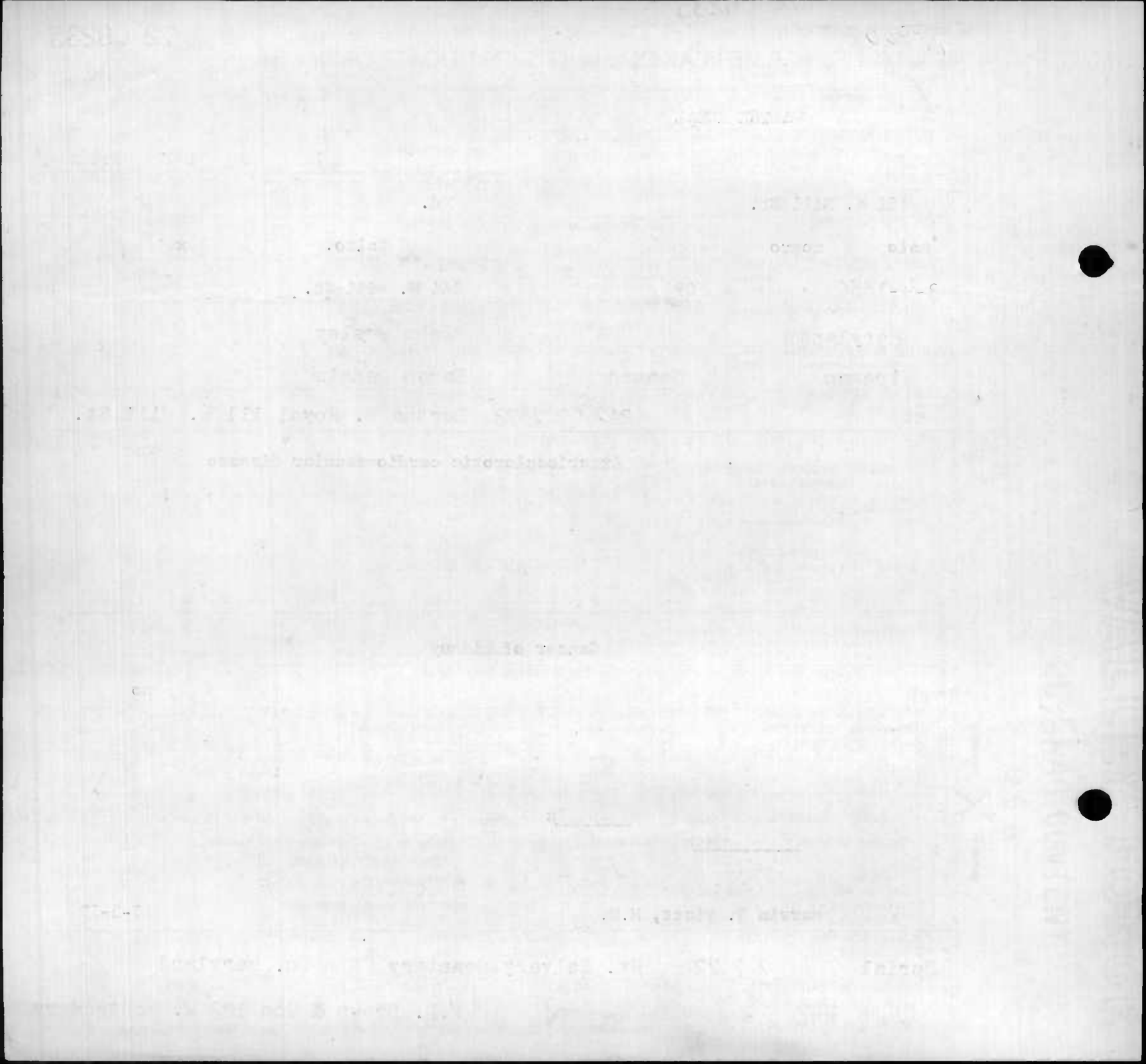
BALTIMORE CITY HEALTH DEPARTMENT

72-06235

STATE OF MARYLAND - DEPT. OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. NAME OF DECEASED (Type or Print) WALTER ROYAL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 111 W. Hill St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 3 1972 9:10a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3-4-1886		10. AGE (In years ? lost birthday) 89	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wesley		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman	
15. MOTHER'S MAIDEN NAME Sarah Dennis		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 217 09 7873		18. INFORMANT ADDRESS Bertha B. Royal 111 W. Hill St.	
19. CAUSE OF DEATH 412.4 + 189.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cancer of kidney			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 7-3-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 7 72	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Frederick J. Brown	
25C. FUNERAL DIRECTOR I, L. Brown & Son		ADDRESS 123 W. Montgomery	



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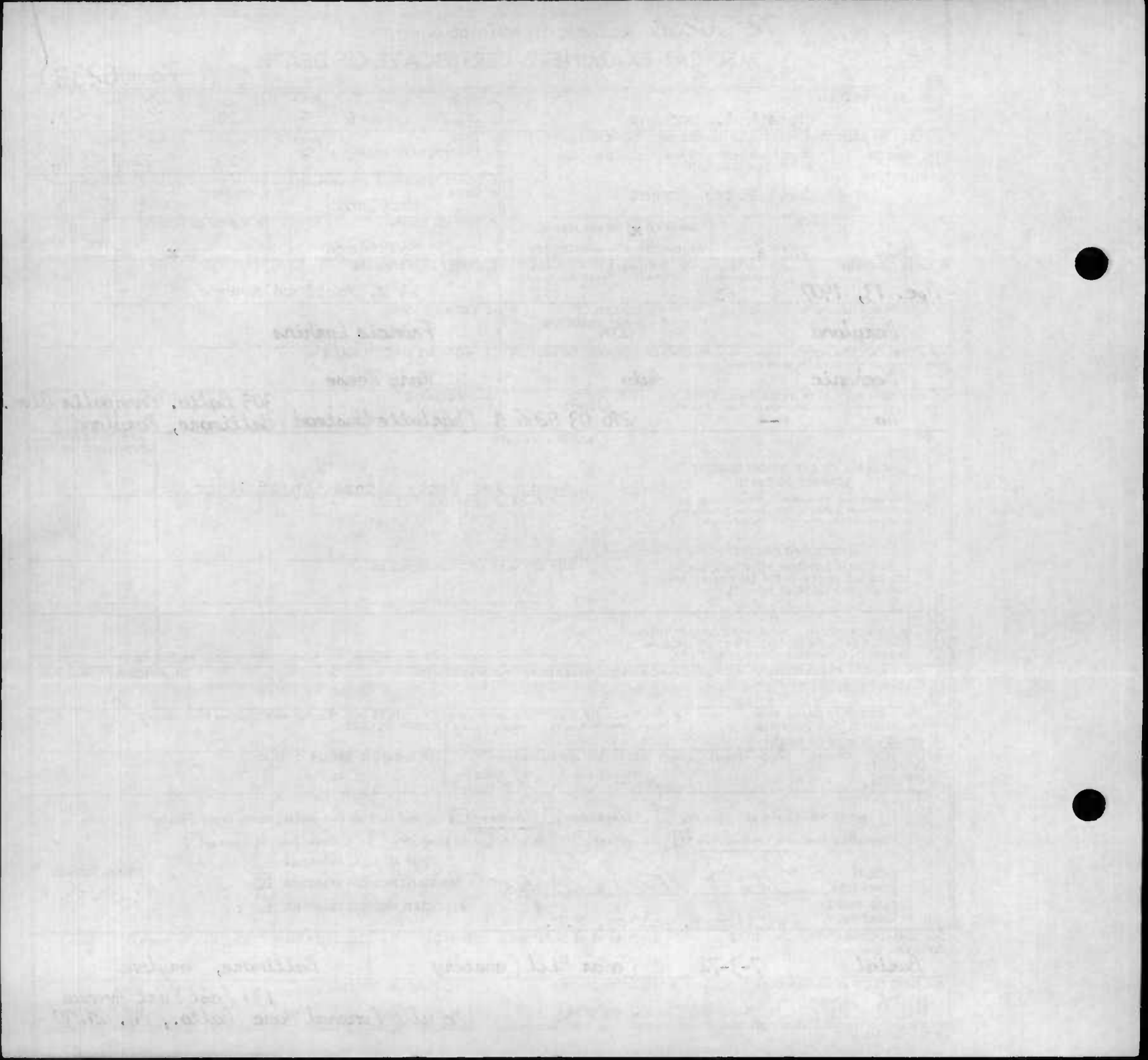
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 66236

BIRTH NO. OF MARYLAND DEATH

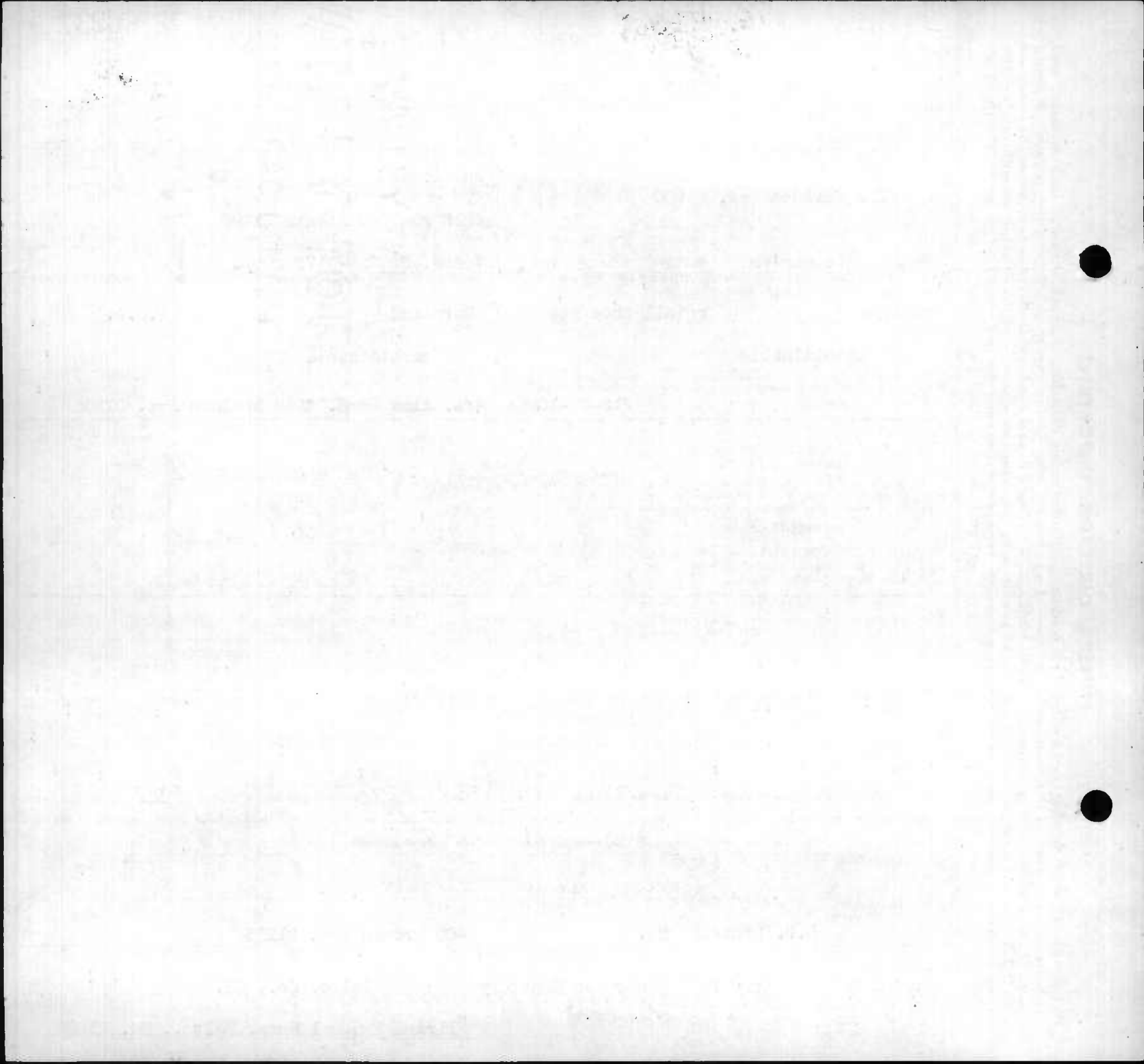
1. NAME OF DECEASED (Type or Print) Joseph A. Larkins		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month 5 Day 20 Year 72 Hour A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 3641 Potte Street		3. DATE PRONOUNCED DEAD Month 5 Day 20 Year 72 2:25 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Dec. 13, 1907		10. AGE (In years last birthday) 64 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		14B. KIND OF BUSINESS OR INDUSTRY Auto	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216 03 9266 A	
15. MOTHER'S MAIDEN NAME Mary Reese		18. INFORMANT Charlotte Umstead	
19. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Fatty alteration of liver DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>W P Mulloy</u> D CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) William P. Mulloy, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-30-72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-72	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Dixie H. H. H.	
25C. FUNERAL DIRECTOR McGully Funeral Home		25D. ADDRESS 130 East Fort Avenue Balto., Md. 21230	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

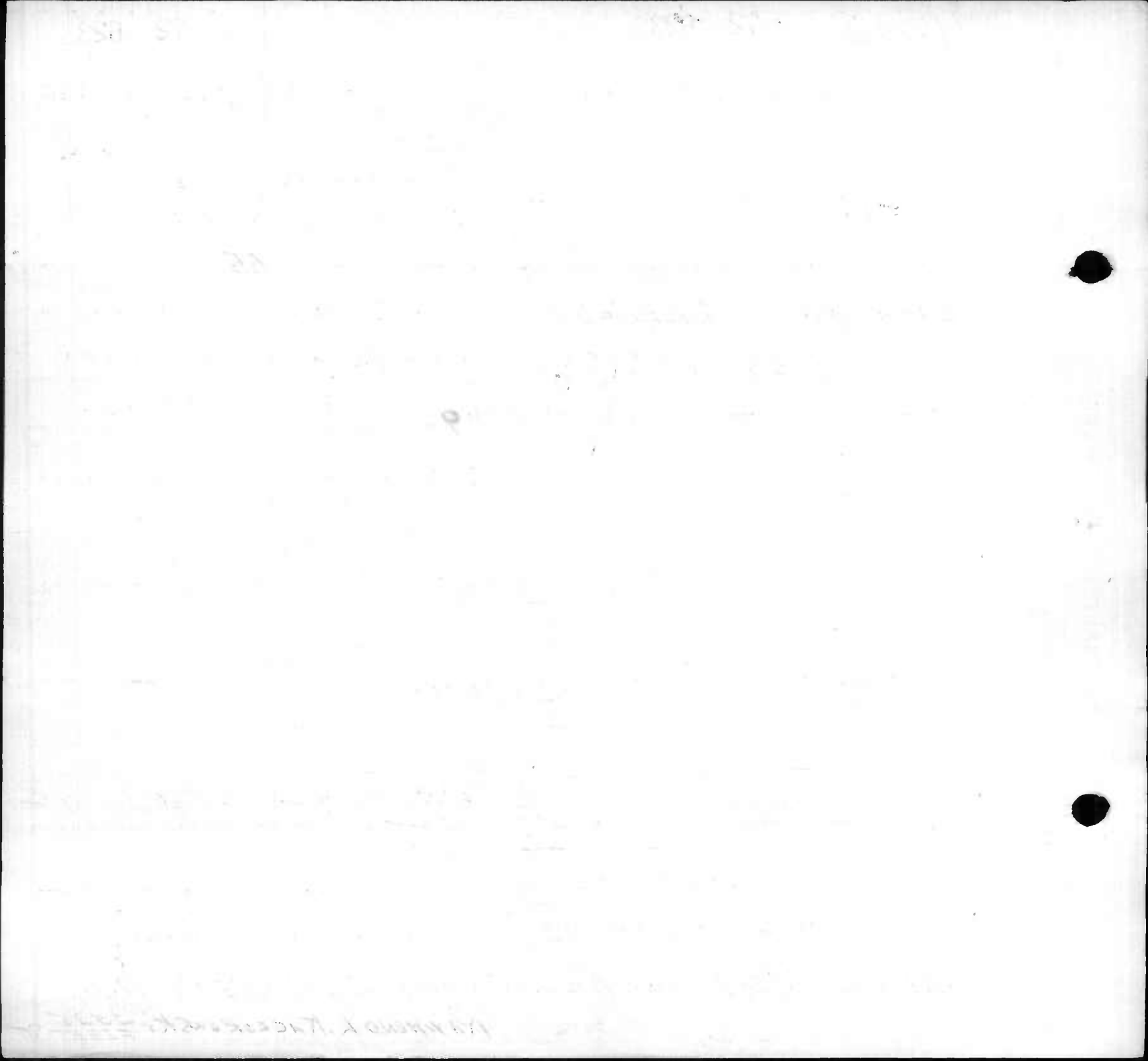
7-630 72 06237				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06237	
BIRTH STATE OF MARYLAND-DEM				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN LOUIS FORD				2. DATE AND HOUR OF DEATH 30 June 1972 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2642			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4238 Sheldon Ave. 21206				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4238 Sheldon Avenue 21206			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 Apr. 93	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) manager		10B. KIND OF BUSINESS OR INDUSTRY retail shoe store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unobtainable				14. MOTHER'S MAIDEN NAME unobtainable			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-01-1098A		17. INFORMANT ADDRESS Mrs. Alma Ford. 4238 Sheldon Ave. 21206			
18. 141.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchio Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/14/70 19 to 6/30 1972, that (I) (we) last saw the deceased alive on 6/27 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE L.B. Stevens MD				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) L.B. Stevens, Ms.				23D. ADDRESS 3400 Erdman Ave. 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 3 July 72		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Dorothy Johnston		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home, Balto., Md. 21206			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-300 72 66238		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 66238
BIRTH DATE OF MARYLAND-DEATH				
1. NAME OF DECEASED (Type or Print) <u>E. FREM, P. POTOCKI</u>		2. DATE AND HOUR OF DEATH <u>6.30.72</u> <u>6.45p.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>103</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME & HOSPITAL</u> <u>35</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>610 S. BERNARD AVE.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8.26.16</u>	9. AGE (In years last birthday) <u>55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>TURNBULK ENT</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>STEPHEN POTOCKI</u>		14. MOTHER'S MAIDEN NAME <u>CIE CELIA KOPYCINISKI</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>125-03-0493</u>		17. INFORMANT <u>V.S. SAILAM, M.D.</u>
18. <u>148.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia, Brain metastases.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few weeks.</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Carcinoma Hypopharynx</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>unprop.</u> <u>10 months</u>
		(C) <u>generalised metastases.</u>		<u>unprop.</u> <u>6 months</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>09.22.71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca of hypopharynx.</u>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>6.15</u> <u>1972</u> to <u>6.30</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>6.30</u> <u>1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.				
23A. SIGNATURE <u>V.S. SAILAM, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6.30.72</u>
23C. PHYSICIAN'S NAME (Type) <u>V.S. SAILAM, M.D.</u>		23D. ADDRESS <u>Church Home & Hospital</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>7/3/72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE Co. MD.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1972</u>		25B. NAME OF REGISTRAR <u>Raymond L. Kaczorowski</u>		25C. FUNERAL DIRECTOR <u>2525 ELEANOR ST.</u>



L-600		72 06238		BALTIMORE CITY HEALTH DEPARTMENT		72 06238	
STATE OF MARYLAND				MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) KATHRYN LEAR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour		3. DATE PRONOUNCED DEAD Month Day Year July 1, 1972		Hour 7:00 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		6. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		E. STREET AND NUMBER 1303 Denbright Road			
9. DATE OF BIRTH 2 28 06		10. AGE (In years lost birth day) 68		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hoffman		14. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) School Teacher		15. MOTHER'S MAIDEN NAME Rath		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT John R Hoffman		ADDRESS 26 Queen Anne Rd			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH E8/2.1 (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Greenville, S.C. Multiple Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rt. 29 and South Entrance Rd. Columbia Md.			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 7-1-72 6:30 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Passenger in auto-truck collision			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/2/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 3 72		24C. NAME OF CEMETERY or CREMATORY Lebanon Rd Church Cem		24D. LOCATION (City, town, or county) (State) Mt Lebanon, Pa	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Sidney [Signature]		25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Highway Balto Md	

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FUNERAL DIRECTOR: IMPORTANT

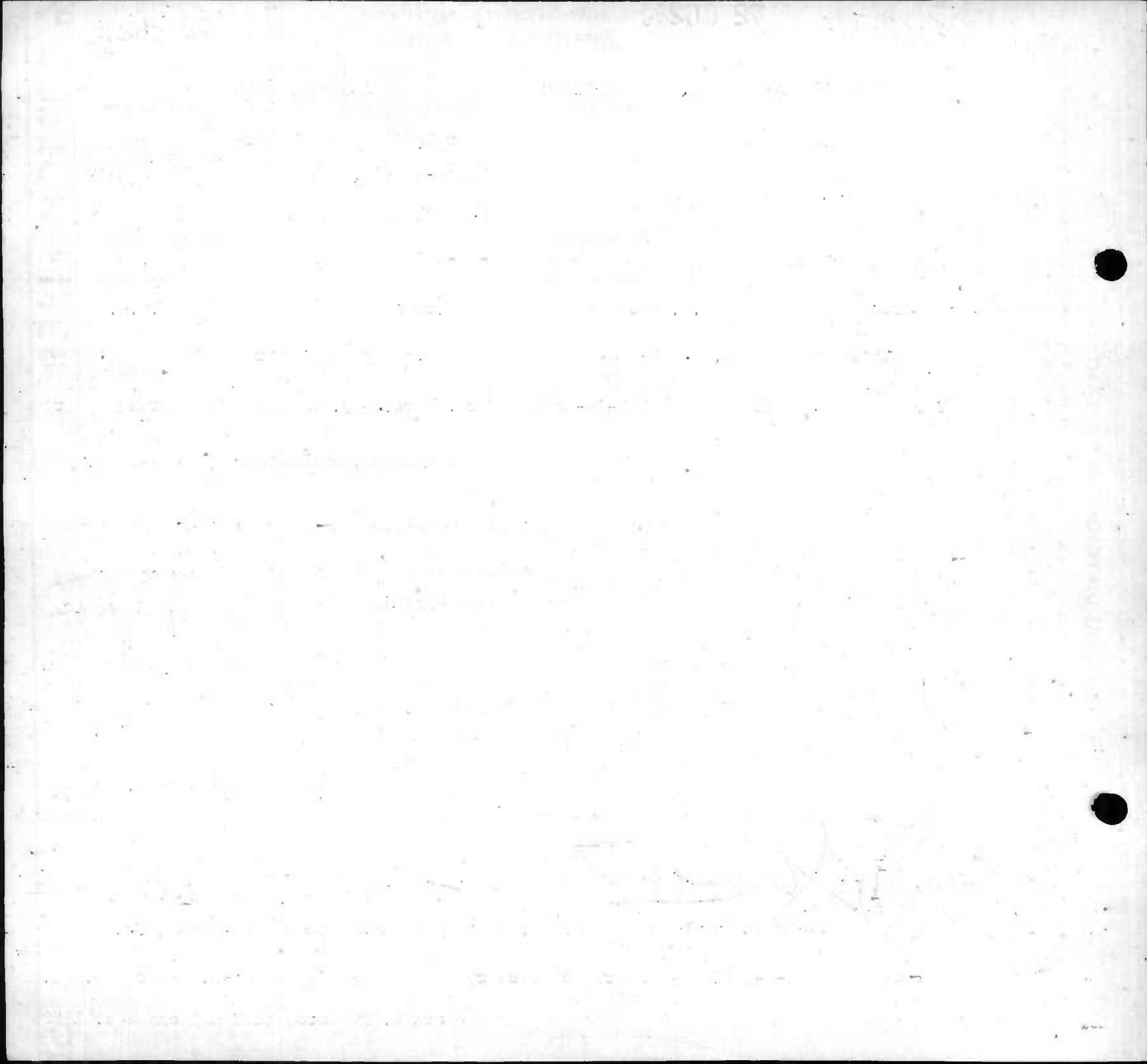
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11-430 72 06240		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06240	
BIRTH DATE OF MARYLAND-DECEASED				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Melka, Agnes				7-1-72 4:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Harbor View 90 1213 Light St.				A. STATE Maryland B. COUNTY Baltimore			
				C. CITY OR TOWN Owings Mills D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER Rosewood State Hospital (June 1958)			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1911	
						9. AGE (in years last birthday) 61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unemployed Mental Patient since 1941				Maryland		United States	
13. FATHER'S NAME Anthony Melka				14. MOTHER'S MAIDEN NAME Agnes Vopalecky			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Chart at Harbor View Nursing Center	
18. 410.0 I + 250.9				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction Minutes			
ANTECEDENT CAUSES				(B) Hypertension and Diabetes Mellitus Years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Chronic Brain Syndrome Years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from August 26 19 69 to July 19 72 that (we) last saw the deceased alive on July 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Peter H. Reinstein, MD						23B. DATE SIGNED 2 July 1972	
23C. PHYSICIAN'S NAME (Type) PETER H. REINSTEIN, MD						23D. ADDRESS Harbor View Nursing Center	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/5/72		Holy Redeemer Cemetery		Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUL 6 1972		Andrew Johnson		Gonce Funeral Home 4001 Ritchie Hwy Balto, Md 21225			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH STATE OF MARYLAND-DEATH		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06241	
1. NAME OF DECEASED (Type or Print) MOHLER A. ROBISON			2. DATE AND HOUR OF DEATH July 1, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Howard C. CITY OR TOWN Ellicott City D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2914 Greenway Drive 21043		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-1914	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY U.S. Custom		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Clarence F. Robison		
14. MOTHER'S MAIDEN NAME Ethelyn Cover			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II		
16. SOCIAL SECURITY NO. 212-09-1562			17. INFORMANT ADDRESS 21043 Mrs. Dorothy E. Robison, 2914 Greenway Drive		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic coronary disease Hypertension and emphysema Hypercholesteremia OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 10 YEARS 10 YEARS 5 YEARS		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 8 19 71 to May 25 19 72 , that (I) (we) last saw the deceased alive on May 25 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) John B. MacGibbon				23B. DATE SIGNED 3 July 1972	
23D. ADDRESS 800 Cathedral Street, Baltimore, Md.		24. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7-5-1972		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Washington Blvd. Howard Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 06242	
1. NAME OF DECEASED (Type or Print) LEVANDOSKI, CATHERINE				2. DATE AND HOUR OF DEATH JULY 2, 1972 7:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL C. CITY OR TOWN GLEN BURNIE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 821 CEDAR BRANCH DRIVE			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03 13 87	9. AGE (In years last birthday) 85	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) MARYLAND
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM THOMPSON				14. MOTHER'S MAIDEN NAME CATHERINE (DUNN)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS OF ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 410.9 + 250.9 Acute antenatal MI. ASCVD				CAUSE OF DEATH Acute antenatal MI. ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 20 19 72 to JULY 2 19 72 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 2 19 72 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.							
23A. SIGNATURE  JOSE APTER, M.D.				23B. DATE SIGNED 07 02 72			
23C. PHYSICIAN'S NAME (Type) JOSE APTER, M.D.				23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-1972		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

LEWANDSKI, CATHERINE

JULY 2, 1972

ST. AGNES HOSPITAL

621 GLENN BLVD. CHICAGO

RENAL TRANSPLANT

03 13 93

WILLIAM THOMPSON

CATHERINE (JUNIOR)

REPORT TO ST. AGNES HOSPITAL
CATON & WILKINS AVE., CHICAGO, ILL.

JOSE PETER, M.D.

ST. AGNES HOSPITAL
CATON & WILKINS AVE., CHICAGO, ILL.

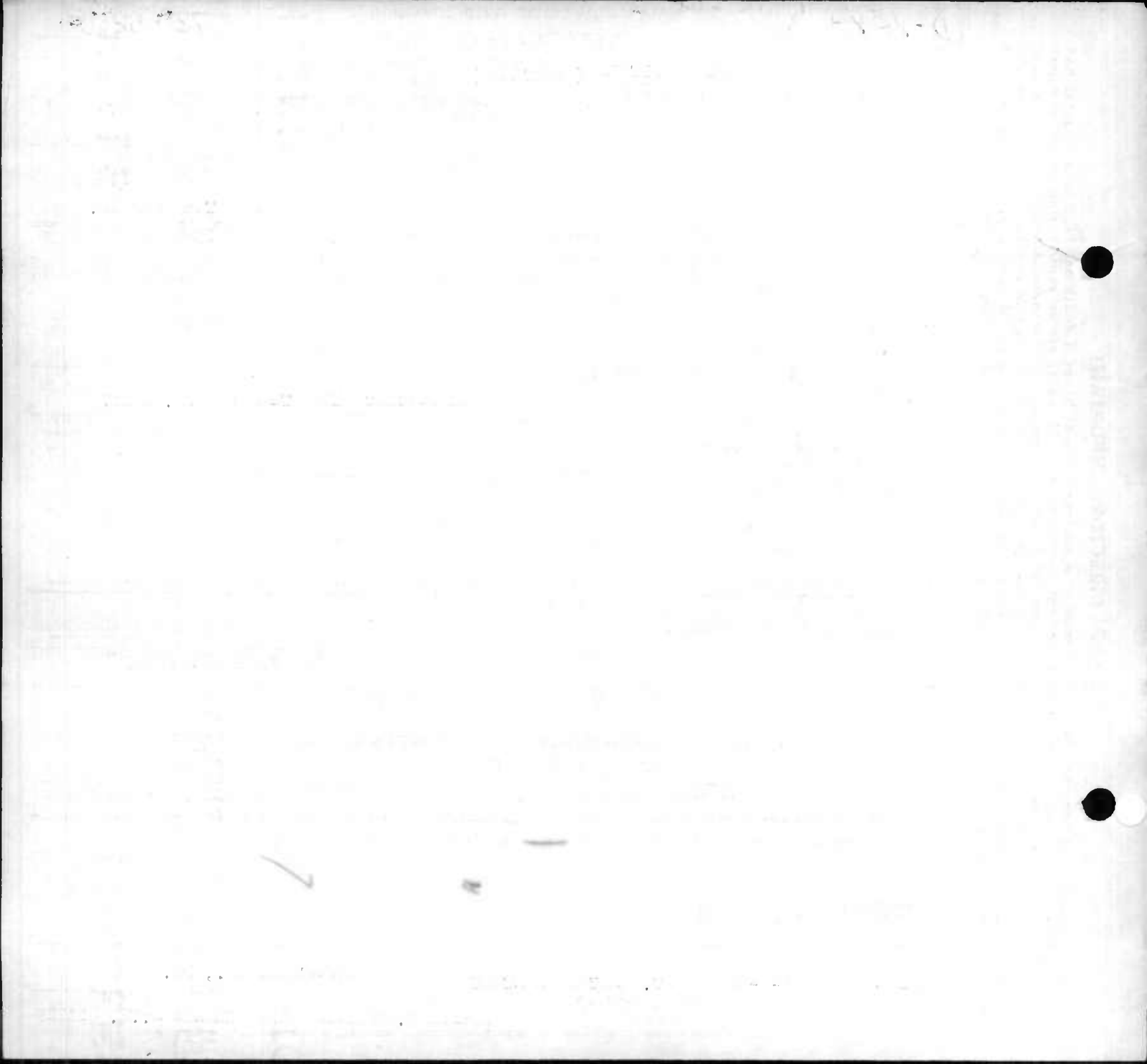
JULY 2

JULY 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

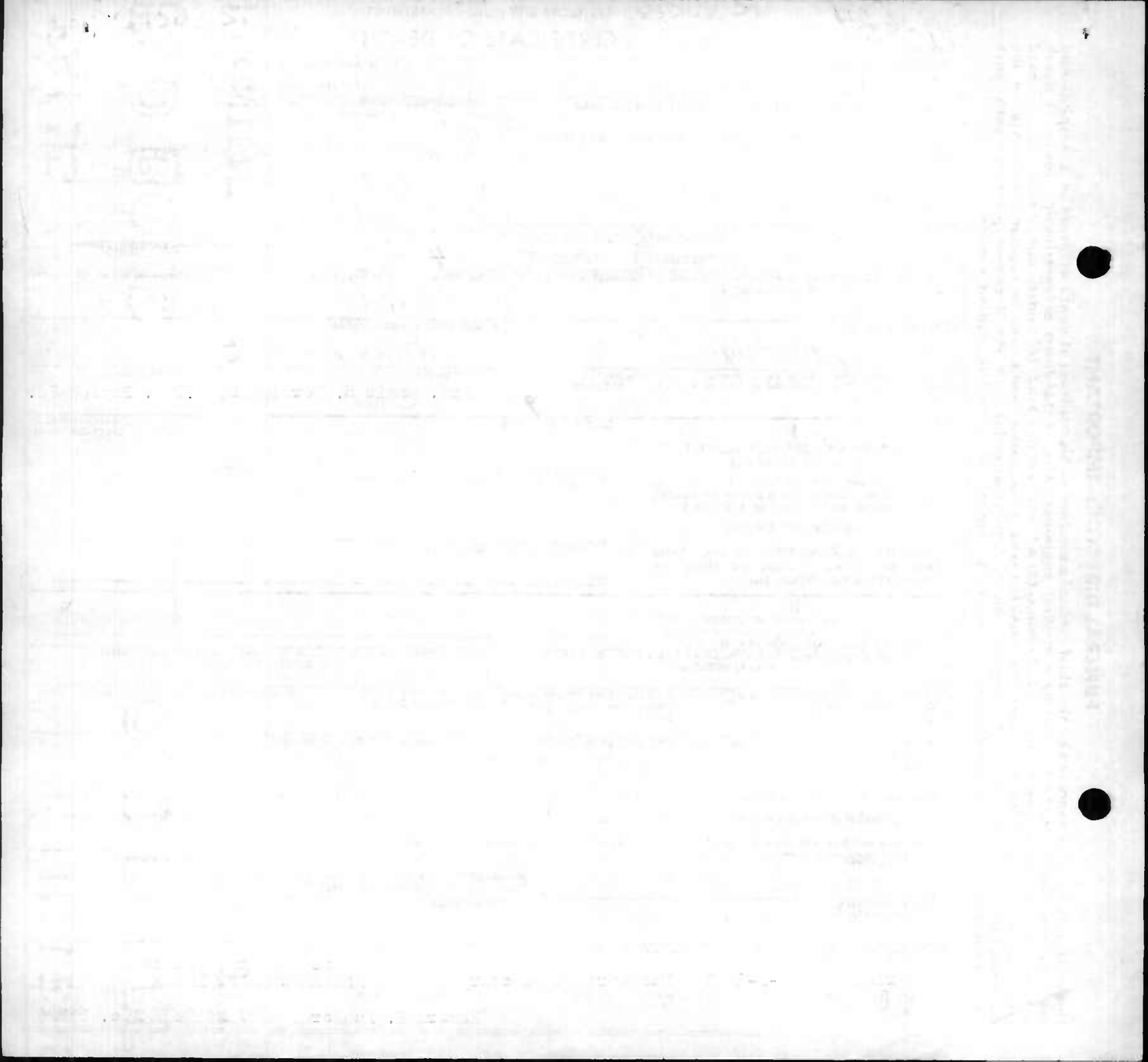
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 66243
1. NAME OF DECEASED (Type or Print) JOSEPH DEPTULA (DETTLER)		2. DATE AND HOUR OF DEATH 7-3-72 3 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME and Hospital IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 35		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE M.D. B. COUNTY Baltimore C. CITY OR TOWN Baltimore MD D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 100 N Broadway 1236 Ten Oaks Rd.		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-1880	9. AGE in years (last birthday) 91
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jahn- Deptula		14. MOTHER'S MAIDEN NAME Rosella- Pawlowski-		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 167-109526		17. INFORMANT ADDRESS John Dettler 1236 Ten Oaks Rd. 21227
18. 4-10-72 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE acute MI - CHF DUE TO, OR AS A CONSEQUENCE OF: (B) CHF DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH a few hours? 2
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical condition)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 2-2-1972 to 3AM 7-3-1972 that (I) (we) last saw the deceased alive on 19th Am 7-2-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Dr. Sajad M.D.		23B. DATE SIGNED 7-3-72-3AM		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) R. S. AJADI		23D. ADDRESS M.D. Church Home and Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7-6-72	24C. NAME of CEMETERY or CREMATORY ST. MARY'S CEMETERY		24D. LOCATION (City, town, or county) (State) ALLEGHENY CO., PA.
25A. DATE RECEIVED BY HEALTH DEPT. JUL 6 1972		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD 4107 WILKENS AVE. 21229		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

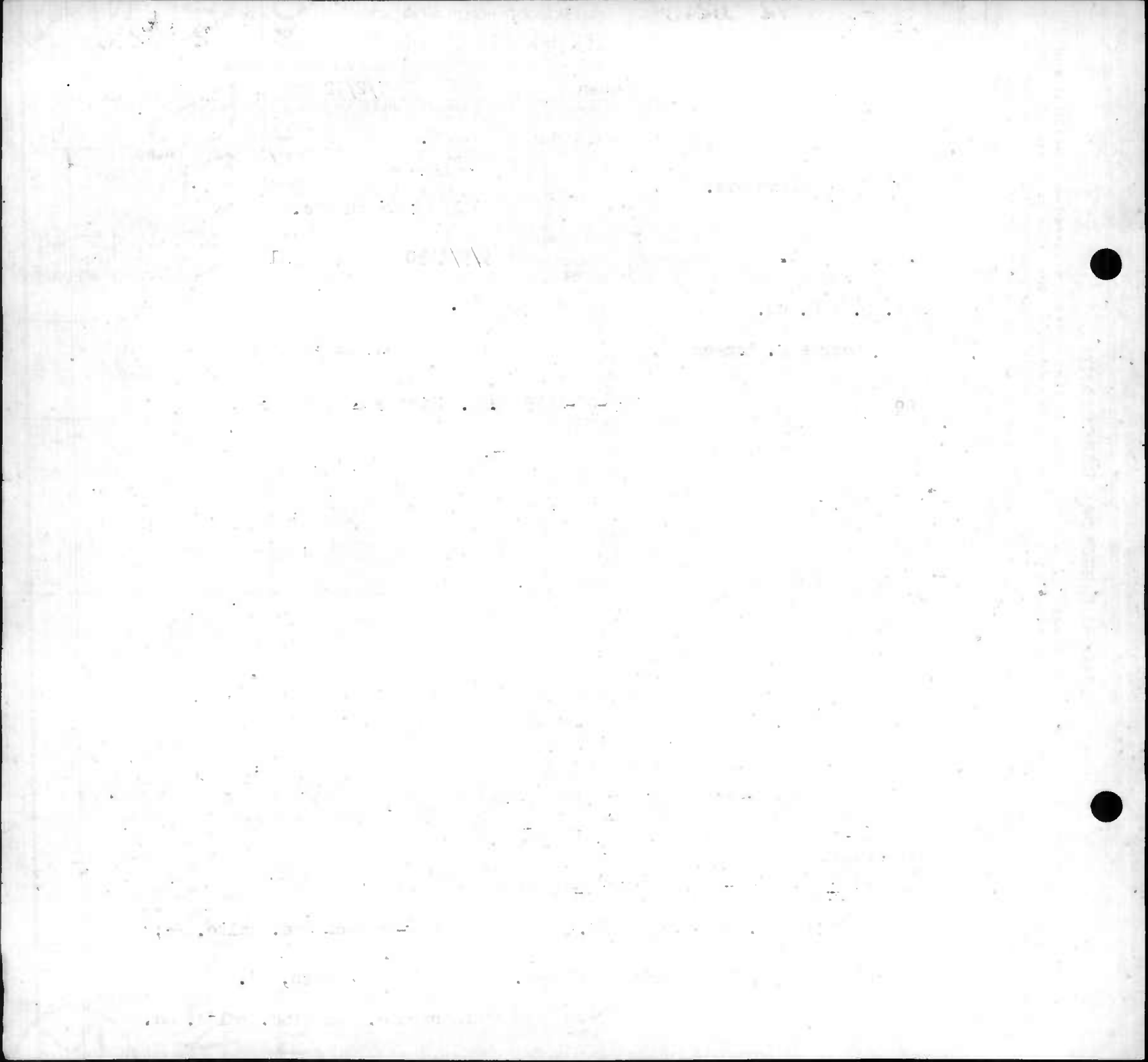
Baltimore City and County				Baltimore City and County		Baltimore City and County	
BIRTH NO. 72-624				REG. NO. 72-6244			
STATE OF MARYLAND - DHMH				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Julius A. Marsiglia</u>				2. DATE AND HOUR OF DEATH <u>June 30, 1972</u> <u>3:09</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>md.</u> B. COUNTY <u>2003</u>			
5. SEX <u>Male</u>		6. RACE <u>Caus.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/14/00</u>	
9. AGE (In years last birthday) <u>71</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Marsiglia</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Liberto</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-32-7928</u>		17. INFORMANT <u>Mrs. Marie E. Marsiglia, 301 S. Payson St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.91</u> <u>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</u> <u>Acute Myocardial Infarction</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</u>				(A) IMMEDIATE CAUSE - <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO.</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> 19 <u>72</u> to <u>6/30</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6/30</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> M.D. DEGREE				23B. DATE SIGNED <u>6/30/72</u>		23C. PHYSICIAN'S NAME (Type) <u>AR VORANEE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-5-1972</u>		<u>Meadowridge Cemetery</u>		<u>Howard County, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1972</u>				25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

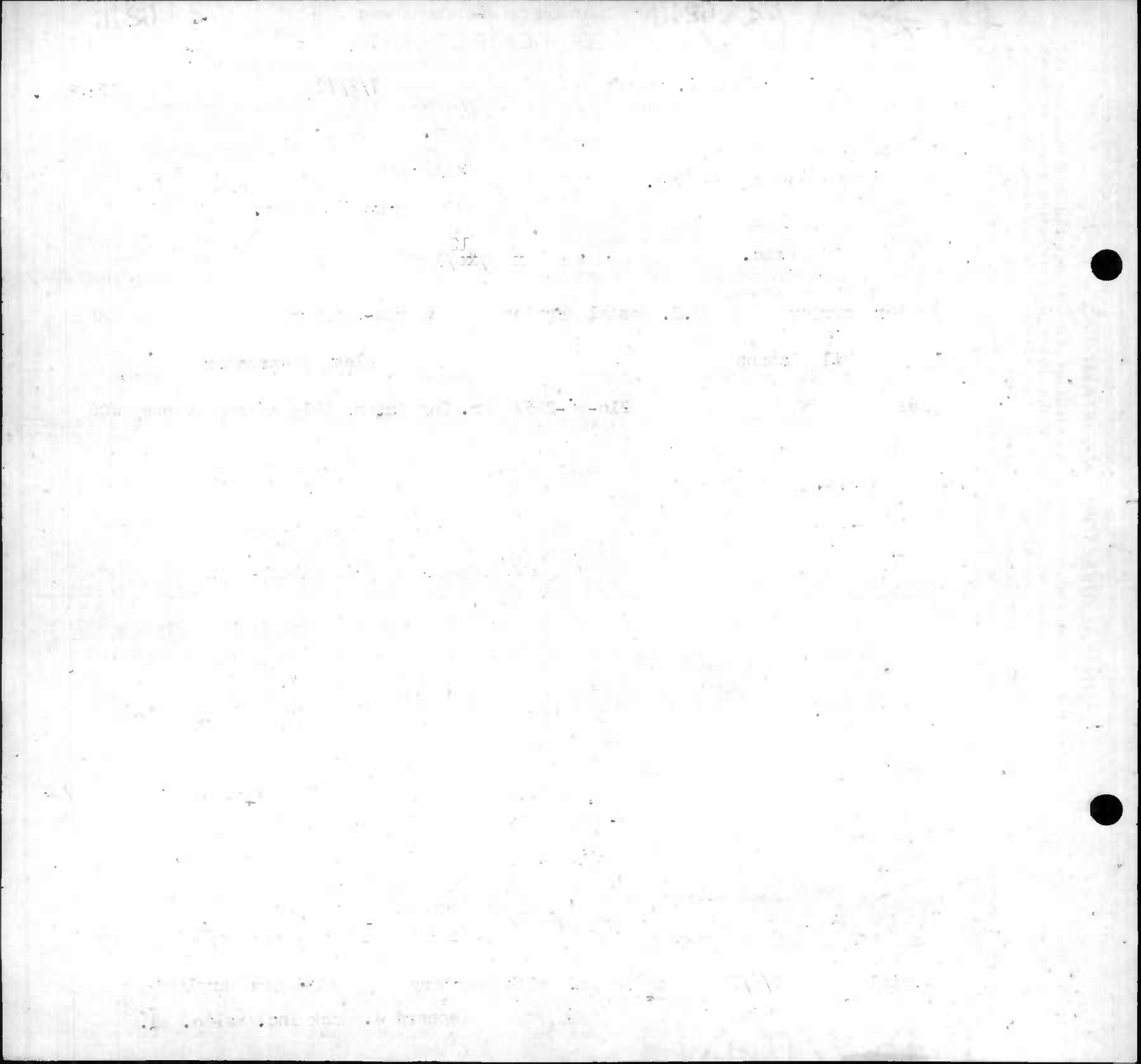
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06245	
<div style="display: flex; justify-content: space-between;"> L-350 72 06245 CERTIFICATE OF DEATH </div>					
BIRTH NO. <u>STATE OF MARYLAND-DHM</u>					
1. NAME OF DECEASED (Type or Print) Harry Bird Louden			2. DATE AND HOUR OF DEATH 7/2/72 7:30 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 3617 Hamilton Ave.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3617 Hamilton Ave.		
5. SEX M.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1890	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. B. & O. RR.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George H. Louden		14. MOTHER'S MAIDEN NAME Bertha Ann Bird	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-07-6529		17. INFORMANT ADDRESS Mrs. Elizabeth Louden same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of the lung metastatic to the brain			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1 1972 to July 2 1972 , that (I) (we) last saw the deceased alive on July 2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald W. Mintzer				23B. DATE SIGNED July 3 1972	
23C. PHYSICIAN'S NAME (Type) Donald W. Mintzer Md.				23D. ADDRESS 3009 Evergreen Ave. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/72		24C. NAME OF CEMETERY or CREMATORY Spring Hill Cem.	
24D. LOCATION (City, town, or county) (State) Easton, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

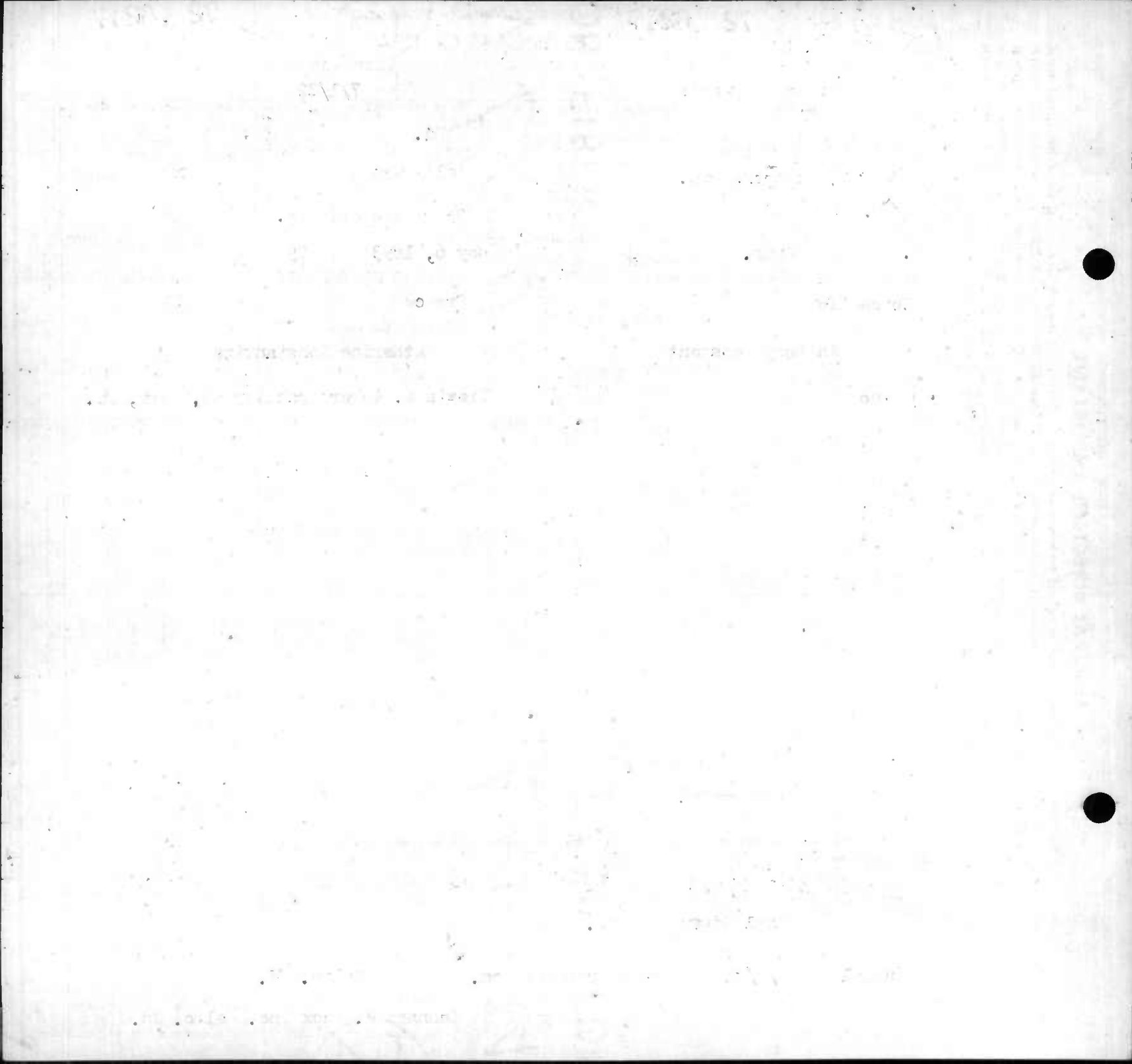
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06246	
CERTIFICATE OF DEATH					
BIRTH NO. L-152 STATE OF MARYLAND-DHMH					
1. NAME OF DECEASED (Type or Print) Julius J. LaBanz			2. DATE AND HOUR OF DEATH 7/2/72 12:01 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4313 Forrest View Ave.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2631		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4313 Forrest View Ave.		
5. SEX M	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/26/1895	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Letter Carrier		10B. KIND OF BUSINESS OR INDUSTRY U.S. Postal Service		11. BIRTHPLACE (State or foreign country) Austria-Hungary	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wil LaBanz			
14. MOTHER'S MAIDEN NAME Eleanor Rashauer		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> WWI			
16. SOCIAL SECURITY NO. 216-46-2257		17. INFORMANT Mr. Guy LaBanz 5215 Eugene Avenue #06			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Hemorrhage 2 hr. (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Metastases 2 d. (C) DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the Tongue 6 mps.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 12 1972 to June 30 1972 , that (I) (we) last saw the deceased alive on June 30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George J. Richards Jr. M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) George J. Richards Jr. M.D.				23D. ADDRESS 6701 N. Charles St 21204	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/72		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972			
25B. NAME OF REGISTRAR Sidney H. Weston		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-650 72 06247				BALTIMORE CITY HEALTH DEPARTMENT		72 06247	
BIRTH NO. STATE OF MARYLAND-DHMH				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Bertha Paris				7/1/72 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 3507 Glenmore Ave.				A. STATE Md.		B. COUNTY 2744	
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3507 Glenmore Ave.							
5. SEX F.	6. RACE Caus.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1893	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Anthony Konstant				14. MOTHER'S MAIDEN NAME Katherine Konstantine			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Travis B. Acker Grantley Ct. York, Pa.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial Infarction (B) Arteriosclerotic Heart Disease (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 20 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/20/72 19 to 7/1/72 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE Paul J. Edgar, M.D.				23B. DATE SIGNED 7/2/72			
23C. PHYSICIAN'S NAME (Type) Paul Edgar MD.				23D. ADDRESS Greece			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/4/72		24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Sidney Weston		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.			



REG. NO.

VS 151-REV. 1/1/68

13. *Explain*

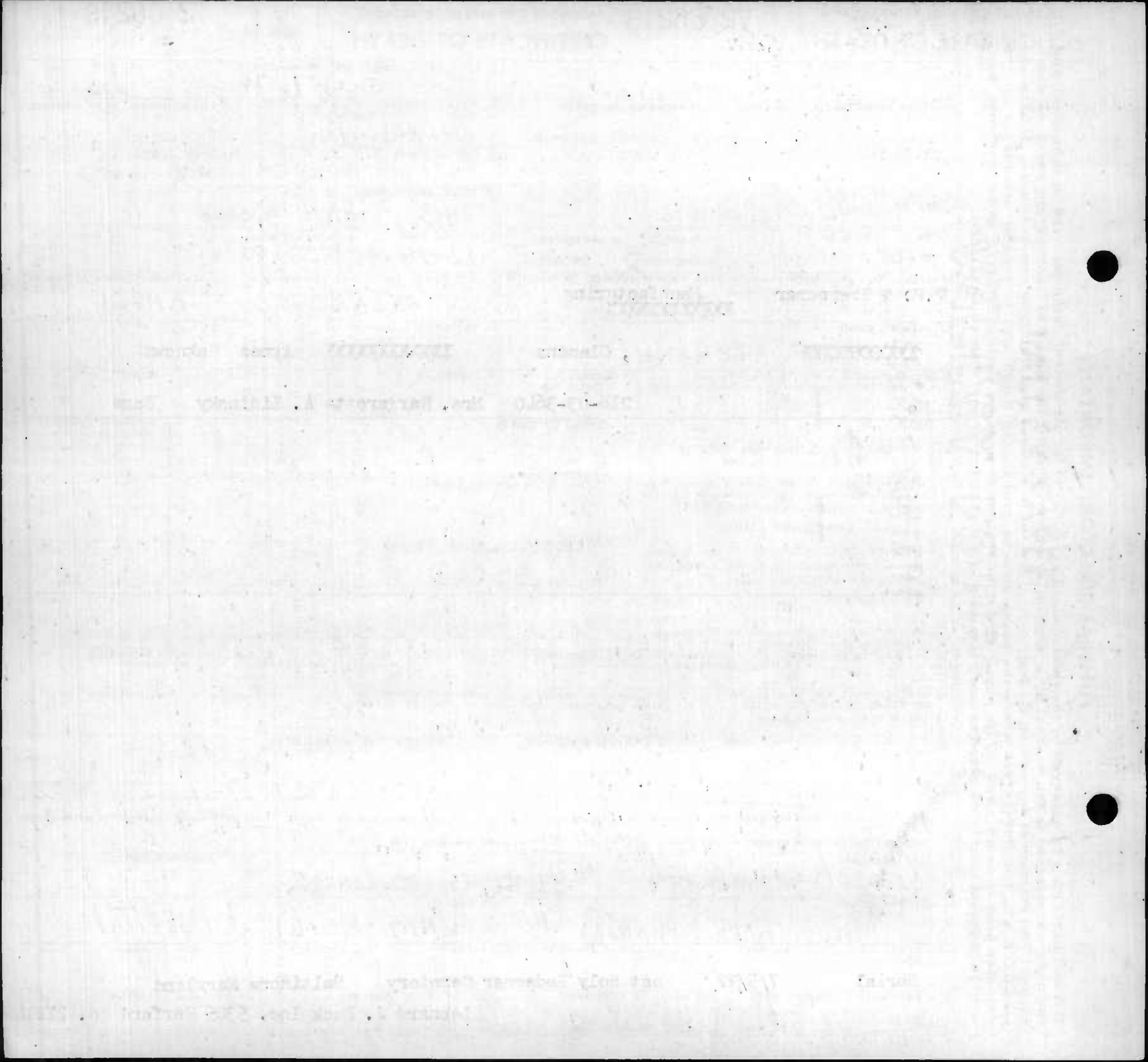
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FUNERAL DIRECTOR: IMPORTANT

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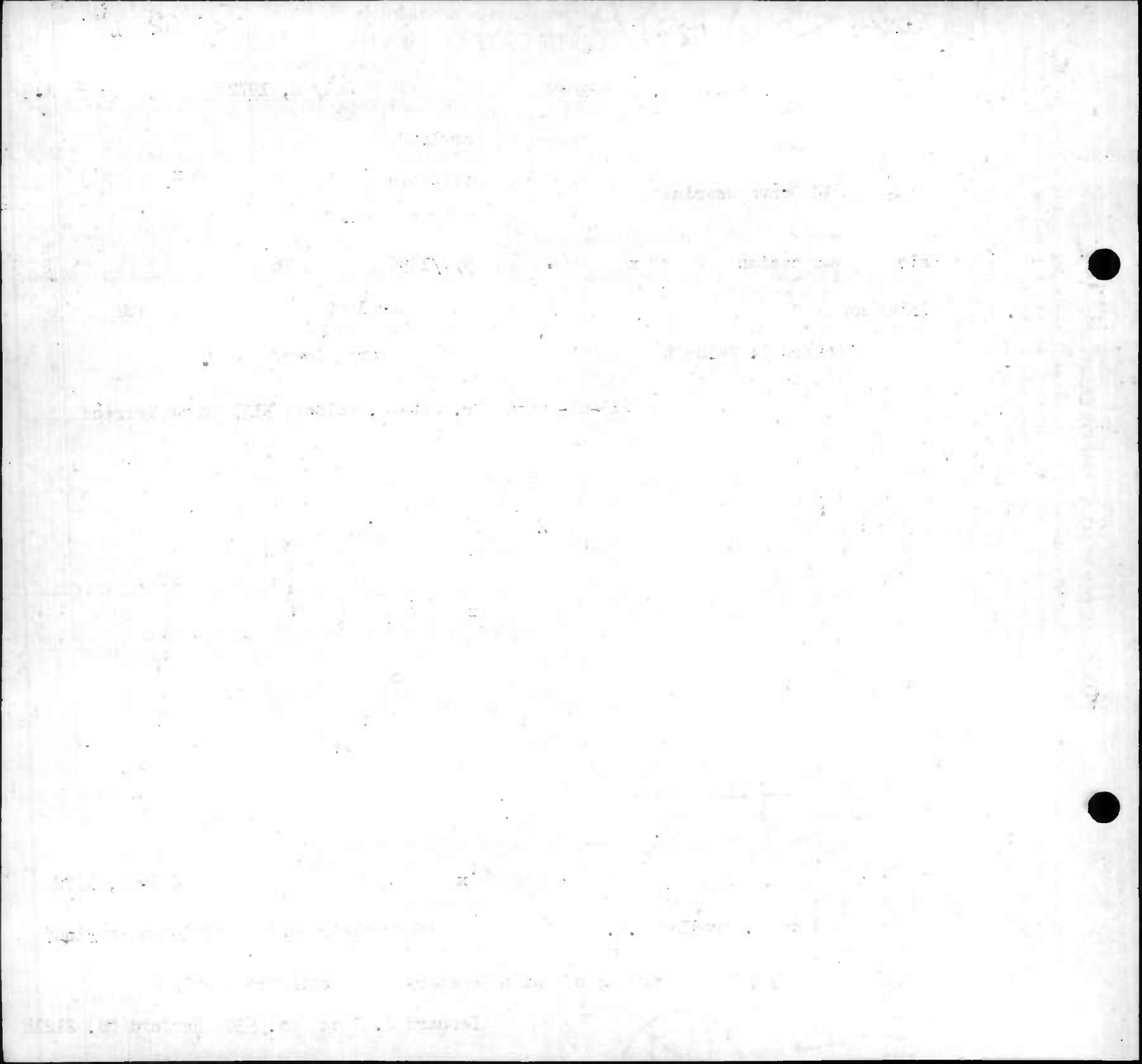
<div style="display: flex; justify-content: space-between;"> 172 06248 72 06248 </div>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. STATE OF MARYLAND-DHCH CERTIFICATE OF DEATH </div>	
<div style="display: flex; justify-content: space-between;"> <div>1. NAME OF DECEASED (Type or Print) Anton C. Athmann</div> <div>2. DATE AND HOUR OF DEATH July 1, 1972 2:00 P.M.</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital</div> <div>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 831 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2413 Pelham Avenue</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>5. SEX MALE</div> <div>6. RACE WHITE</div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>8. DATE OF BIRTH 12-14-90</div> <div>9. AGE (In years last birthday) 81</div> <div>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>10A. USUAL OCCUPATION (Give kind of work if retired) RETIRED - MANUFACTURING</div> <div>10B. KIND OF BUSINESS OR INDUSTRY MANUFACTURING</div> <div>11. BIRTHPLACE (State or foreign country) MARYLAND</div> <div>12. CITIZEN OF WHAT COUNTRY? AMERICAN</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>13. FATHER'S NAME ATHMANN, Clemens</div> <div>14. MOTHER'S MAIDEN NAME Agnes Unknown</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</div> <div>16. SOCIAL SECURITY NO. 216-03-3640</div> <div>17. INFORMANT Mrs. Margaretta A. Lidinsky</div> <div>ADDRESS Same</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>18. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) PNEUMONIA ASCVD</div> <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>19A. DATE OF OPERATION 0</div> <div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div>20A. AUTOPSY? (Yes or No) NO</div> <div>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</div> <div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div> <div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</div> <div>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div> <div>21F. HOW DID INJURY OCCUR?</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>22. I certify that (I) (this hospital) attended the deceased from 6-30-72 19 72 to 7-1 19 72, that (I) (we) last saw the deceased alive on 7-1 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>23A. SIGNATURE Miguel Karacuschansky M.D.</div> <div>23B. DATE SIGNED 7-1-72</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>23C. PHYSICIAN'S NAME (Typo) MIGUEL KARACUSCHANSKY M.D.</div> <div>23D. ADDRESS UNION MEMORIAL Hospital</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</div> <div>24B. DATE 7/5/72</div> <div>24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer Cemetery</div> <div>24D. LOCATION (City, town, or county) (State) Baltimore Maryland</div> </div>	
<div style="display: flex; justify-content: space-between;"> <div>25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972</div> <div>25B. NAME OF REGISTRAR Sidney Johnston</div> <div>25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. 21214</div> </div>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

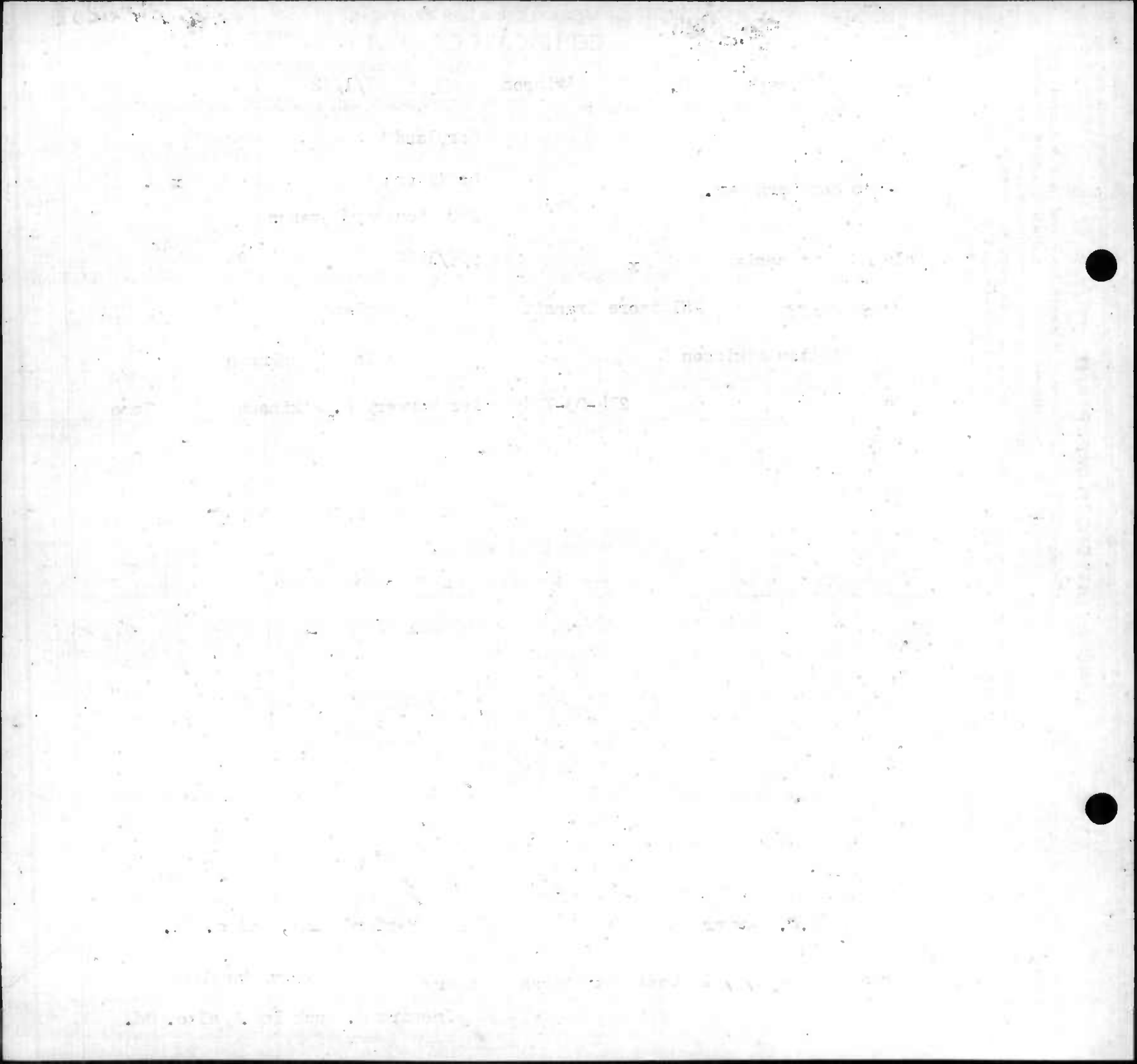
J-413 72 06250		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06250	
BIRTH NO. STATE OF MARYLAND - DHMH		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ARTHUR T. TALBOTT		July 4, 1972		9:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY 2641	
90 Gould Convalesarium		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5604 Todd Avenue			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/1895	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Richard A. Talbott		14. MOTHER'S MAIDEN NAME Mary Lowry		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-3568A		17. INFORMANT Mr. Otto J. Talbott 5111 Edgar Terrace	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Antisclerotic Heart Disease</i> (B) <i>Generalized Atherosclerosis</i> (C) <i>Coccyx; Injury Retention; Probable wound Stitches</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/29/1972 to 7/4/1972, that (I) (we) last saw the deceased alive on 6/29/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>Albert B. Bradley</i>		23B. DATE SIGNED July 5, 1972			
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley M.D.		23D. ADDRESS 4900 Belair Road Baltimore Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/72		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Baltimore Maryland		24E. NAME OF REGISTRAR Dudley Johnson		24F. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. 21214	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

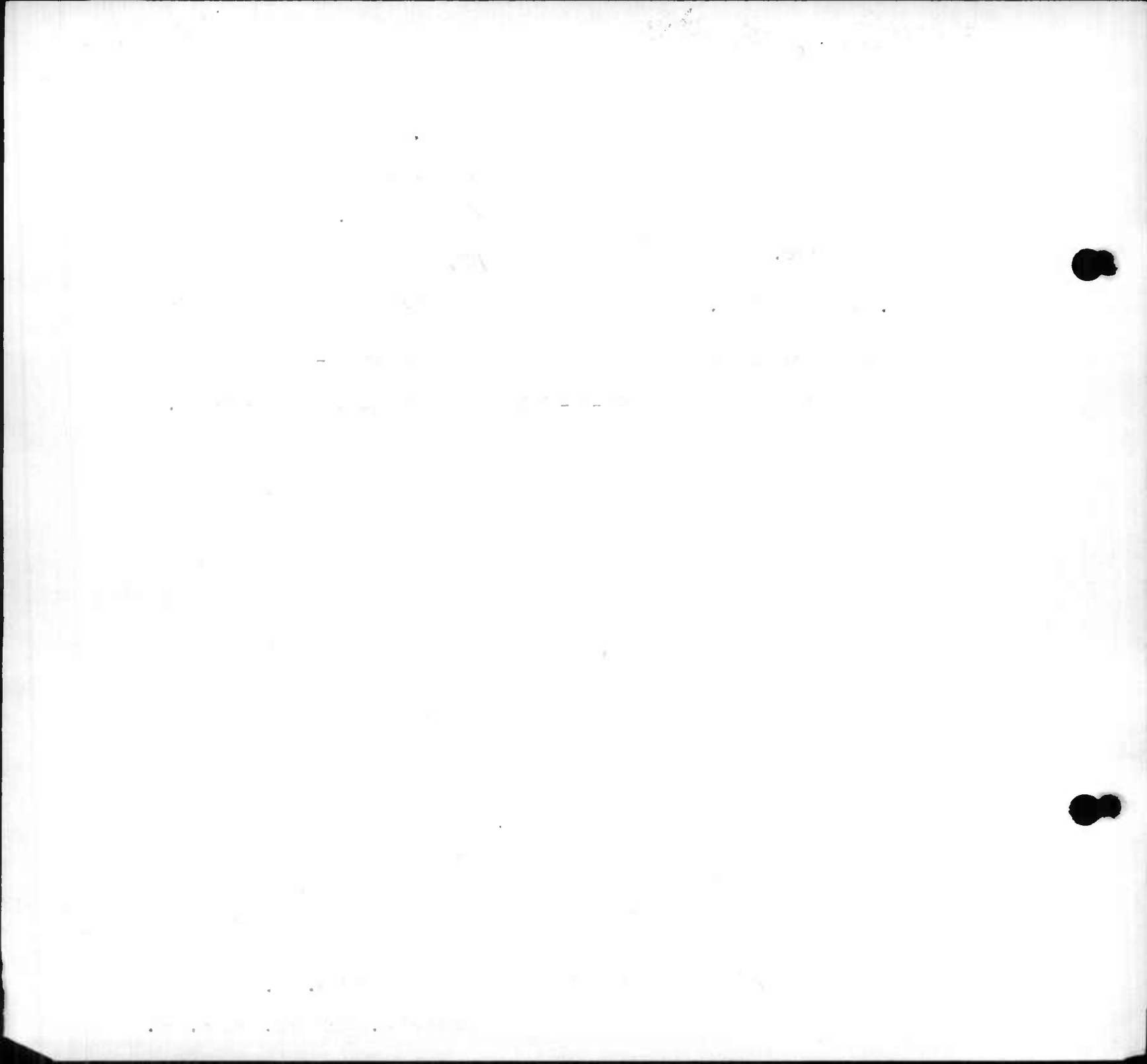
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 6251	
CERTIFICATE OF DEATH					
BIRTH NO. A-325 72 6251		STATE OF MARYLAND-DEMH			
1. NAME OF DECEASED (Type or Print) George C. Atkinson			2. DATE AND HOUR OF DEATH 7/1/72 94 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2506 Southern Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2733 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2506 Southern Avenue		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/1887	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Staff		10B. KIND OF BUSINESS OR INDUSTRY Baltimore Transit		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME William Atkinson		
14. MOTHER'S MAIDEN NAME Ella Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 214-03-7785			17. INFORMANT Miss Margery A. Atkinson		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4/2.2 I AZOTEMIA (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. nephrosclerosis 5 yrs.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic C. V. Dis (Congst.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from July 6, 1965 to July 1, 1972 , that (I) (we) last saw the deceased alive on June 30, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE G. J. Sawyer MD				23B. DATE SIGNED 7/1/72	
23C. PHYSICIAN'S NAME (Type) G. J. Sawyer MD				23D. ADDRESS 4808 Harford Road, Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/72		24C. NAME OF CEMETERY or CREMATORY West Nottingham Cemetery	
24D. LOCATION (City, town, or county) (State) Colora Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972			
25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

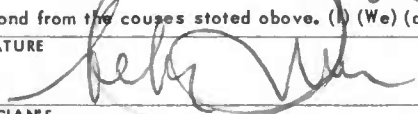
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> D-412 72 06252 BALTIMORE CITY HEALTH DEPARTMENT </div>		<div style="display: flex; justify-content: space-between;"> REG. NO. 72 06252 </div>	
CERTIFICATE OF DEATH			
BIRTH NO. Valentino DelViscio		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) Delviscio, Valentino		2. DATE AND HOUR OF DEATH 7-1-72 5:03 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital, 827, Linden Avenue, 48 Balto, Md.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2741	
5. SEX M		6. RACE Cauc.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/22/1895	
9. AGE (in years last birthday) 77		10. IF UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Armco Steel Co.		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Matteo DeViscio	
14. MOTHER'S MAIDEN NAME Rosina		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI	
16. SOCIAL SECURITY NO. 212-18-8133		17. INFORMANT ADDRESS Frank DelViscio 3503 Losrac Ct.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio-respiratory Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Suspected Cancer Lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-24-1972 to 7-1-1972 that (I) (we) last saw the deceased alive on 7-1-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ahmad		23B. DATE SIGNED 7-1-72	
23C. PHYSICIAN'S NAME (Type) DR. AHMAD		23D. ADDRESS Maryland Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/72	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.	
25C. FUNERAL DIRECTOR ADDRESS Balto. Md.		25D. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 06253		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06253
STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) SAMUEL WEBSTER SLABAUGH		2. DATE AND HOUR OF DEATH June 30, 1972 9:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) DOA: UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 905 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 911 Gorsuch Avenue		
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/1903	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Noah Slabaugh		14. MOTHER'S MAIDEN NAME Phoebe Saunders		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-1736		17. INFORMANT Mrs. Lettie L. Slabaugh
18. 485 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). cardio megly - congestive heart failure		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) cardio megly - congestive heart failure		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6-13-72 19 to 6-27-72 19 that (I) (we) last saw the deceased alive on 6-27-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED 7/1/72		
23C. PHYSICIAN'S NAME (Type) Dr. Sebastian Russo		23D. ADDRESS 5017 Harford Rd, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/72		24C. NAME OF CEMETERY or CREMATORY Maryland National Memorial
24D. LOCATION (City, town, or county) Laurel Maryland		24E. STATE (State) Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Anthony J. Ruck		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.
25D. ADDRESS Balto, Md.				

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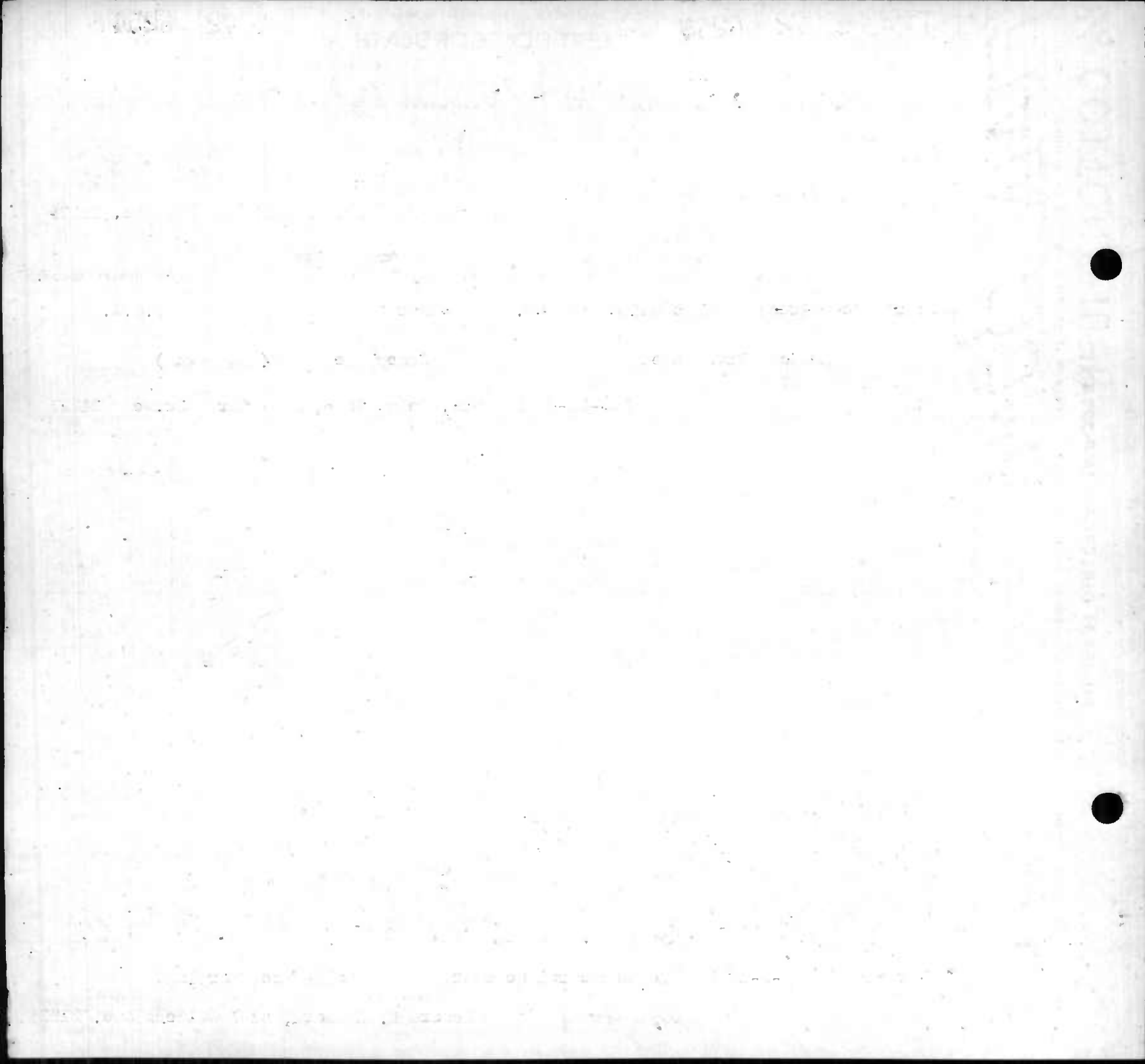
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-532 72 06254		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06254	
BIRTH NO. STATE OF MARYLAND-DHMH							
1. NAME OF DECEASED (Type or Print) <u>Jantz, Josephine V.</u>				2. DATE AND HOUR OF DEATH <u>7-2-72</u> <u>7:40</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Caton Manor Nursing Center</u>				A. STATE <u>MD.</u>		B. COUNTY <u>AA</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Brooklyn</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>3911 2nd Ave. 21225</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/25/91</u>	9. AGE (In years last birthday) <u>81</u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Seamstress</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Hochchild Kohn Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
13. FATHER'S NAME <u>Louis Kraushofer</u>				14. MOTHER'S MAIDEN NAME <u>Josephine (Unknown)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-22-0053</u>		17. INFORMANT ADDRESS <u>Mrs. Helen Sabo, 5807 Heron Drive 21227</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute coronary occlusion</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCA</u> (C) <u>severe decubitus. buttock</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>yes</u>			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-16 1972</u> to <u>7-2 1972</u> that (I) (we) last saw the deceased alive on <u>7-2 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>H. Nakazawa</u>				23B. DATE SIGNED <u>7-2-72</u>		23C. PHYSICIAN'S NAME (Type) <u>H. NAKAZAWA</u>	
23D. ADDRESS <u>3350 Wilkens Ave. Balto Md</u>				23E. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-5-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1972</u>		25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. H-656 72 06255				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06255	
STATE OF MARYLAND - DHME				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Horner, Bessie J.				2. DATE AND HOUR OF DEATH July 4, 1972 2:00 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CATON MANOR NURSING CENTER 3330 WILKENS AVENUE BALTIMORE, MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2854 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4732 Dartford Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-17-1885		9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME XXXXXX - Will Kelly				14. MOTHER'S MAIDEN NAME XXXXXX Louise (Unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) XX		16. SOCIAL SECURITY NO. 218-24-5076		17. INFORMANT ADDRESS Mr. Willis Horner, 4732 Dartford Ave. 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Terminal Hypostatic Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. General aye Cerebral Arterio Sclerotic Encephalopathy				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: General aye Cerebral Arterio Sclerotic Encephalopathy (B) DUE TO, OR AS A CONSEQUENCE OF: W.C.U.S. (C) See above		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years 20 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). See above Diabetes Mellitus							
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/2 1954 to 7/4 1972 , that (I) (we) last saw the deceased alive on 7/3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. My associates							
23A. SIGNATURE E. W. Johnson				23B. DATE SIGNED 7/5/72		23C. PHYSICIAN'S NAME (Type) Dr. E. W. Johnson	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-7-1972		24C. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972				25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS Webster Funeral Home, Princess Anne, Md.	
24D. LOCATION (City, town, or county) (State) Deal Island, Maryland				25D. ADDRESS Route 3			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06256		BALTIMORE CITY HEALTH DEPARTMENT	
7-400		72 06256	
BIRTH NO. <u>7-400</u>		STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) <u>Feehly, George A. JR.</u>		2. DATE AND HOUR OF DEATH <u>7/2/72</u> <u>6 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Pasadena</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u>		C. CITY OR TOWN <u>Pasadena</u>	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <u>767 Woods Rd.</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-27</u>
9. AGE (In years last birthday) <u>45</u>		10. Under 1 Yr. Months: _____ Days: _____	11. Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Feehly, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Olive Uphole</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW2</u>		16. SOCIAL SECURITY NO. <u>WW2</u>	
17. INFORMANT <u>BCH Records:</u>		4940 Eastern Ave. ADDRESS <u>Baltimore, Md. 21224</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>2.05.01</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (If stating the UNDERLYING CONDITION last.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardio Pulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Dec 1971</u> <u>→ 7/2/72</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/24/1972</u> to <u>7/2/1972</u> that (I) (we) last saw the deceased alive on <u>7/2/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Ronald G. Banks</u> M.D. DEGREE		23B. DATE SIGNED <u>7/2/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>RONALD G. BANKS</u> M.D. DEGREE		23D. ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21214</u> <u>Baltimore City Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/6/72</u>	24C. NAME of CEMETERY or CREMATORY <u>Immaculate Conception Cemetery, Cherry Hill, Maryland</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore City</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1972</u>		25B. NAME OF REGISTRAR <u>Edw. J. Johnston</u>	
25C. FUNERAL DIRECTOR <u>Ralph G. Hickey</u>		ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u>	

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CERTIFICATE OF DEATH

BIRTH NO. W-420 STATE OF MARYLAND - DETH1. NAME OF DECEASED
(Type or Print)Betty A. WILLIG

2. DATE AND HOUR OF DEATH

June 30, 1972

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospitals4940 Eastern AvenueBaltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before death)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN

ESSEX

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

212 Riverthorn Road 21220

5. SEX

Female

6. RACE

Caucasian7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

6/2/19459. AGE (In years
last birthday)2711 Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)NONE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MO.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Martin Willig

14. MOTHER'S MAIDEN NAME

EDITH GUTTRIDGE15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)NO16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

BCH Records 4940 Eastern Ave. 21224

18.

592X1

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

SEPSIS

DUE TO, OR AS A CONSEQUENCE OF:

4-5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Chronic Kidney infectionBilateral Staghorn Calculi

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).Cerebral palsy

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

019B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(the)~~ (this hospital) attended the deceased from 6/30 19 72 to 6/30 19 72,
that ~~(he)~~ (we) last saw the deceased alive on 6/30 19 72 and that in ~~(my)~~ (our) opinion death occurred on the date
and hour and from the causes stated above, ~~(he)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE

Adel Z. Makary M.D.Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

6/30/7223C. PHYSICIAN'S
NAME (Type)ADEL Z. MAKARY

23D. ADDRESS

Baltimore City Hospitals4940 Eastern Ave. Baltimore, Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)BURIAL

24B. DATE

7/3/72

24C. NAME of CEMETERY or CREMATORY

SACRED HEART

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

JUL 6 1972

25B. NAME OF REGISTRAR

Anthony J. Thornton

25C. FUNERAL DIRECTOR

J. J. Connolly, 300 West Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

REG. NO.

6257

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH															
BIRTH NO. <u>M-534</u> <u>72-6258</u> STATE OF <u>MARYLAND</u> DEPT. <u>DHMS</u>				2. DATE AND HOUR OF DEATH <u>7/3/72</u> <u>8:00</u>															
1. NAME OF DECEASED (Type or Print) <u>JEANETTE MINDEL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence) <table border="1" style="width: 100%;"> <tr> <td colspan="2">A. STATE <u>MARYLAND</u></td> <td colspan="2">B. COUNTY <u>2711</u></td> </tr> <tr> <td colspan="2">C. CITY OR TOWN <u>BALTIMORE</u></td> <td colspan="2">D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></td> </tr> <tr> <td colspan="4">E. STREET AND NUMBER <u>5723 UFFINGTON ROAD #21209</u></td> </tr> </table>				A. STATE <u>MARYLAND</u>		B. COUNTY <u>2711</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>5723 UFFINGTON ROAD #21209</u>			
A. STATE <u>MARYLAND</u>		B. COUNTY <u>2711</u>																	
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
E. STREET AND NUMBER <u>5723 UFFINGTON ROAD #21209</u>																			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00 5723 UFFINGTON ROAD</u>																			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 12, 1907</u>	9. AGE (In years lost birthday) <u>64</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>													
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>													
13. FATHER'S NAME <u>SAMUEL SHOCHET</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA ?</u>															
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-48-0753</u>		17. INFORMANT ADDRESS <u>MR. CHARLES MINDEL, 5723 UFFINGTON ROAD #21209</u>															
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>157.9 I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cancer of Pancreas</u> (B) <u>with Metastases to liver</u> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>onset Sept 21</u>															
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____																			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____													
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____															
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____															
22. I certify that (I) (this hospital) attended the deceased from _____ 19 to _____ 19 , that (I) (we) last saw the deceased alive on _____ 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <u>Sol Smith</u>				23B. DATE SIGNED _____		23C. PHYSICIAN'S NAME (Type) <u>SOL SMITH</u>													
23D. ADDRESS <u>6810 PARK HEIGHTS AVENUE</u>				24. LOCATION (City, town, or county) (State) <u>REISTERSTOWN, MARYLAND</u>															
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/5/1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>		24D. LOCATION (City, town, or county) (State) <u>REISTERSTOWN, MARYLAND</u>													
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>															

M.

(more omission)

72 06258

REG. NO.

DEPARTMENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72-68258
W-516 72 68258		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) SIDNEY WEINBERG		2. DATE AND HOUR OF DEATH JULY 2, 1972 10 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3653 GLENGYLE AVENUE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2720		
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 3653 GLENGYLE AVENUE #21215		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 17, 1922	9. AGE (In years last birthday) 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BODY & FENDER		10B. KIND OF BUSINESS OR INDUSTRY ATO		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH WEINBERG		
14. MOTHER'S MAIDEN NAME SARAH KAMMERMAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II NAVY		
16. SOCIAL SECURITY NO. 266-36-9800		17. INFORMANT ADDRESS MRS. FREIDA WEINBERG, 3653 GLENGYLE AVENUE		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: acute myocardial inf</p> <p>(B) ASND E HOSP DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> </div>				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7/2 19 72 to 7/3 19 72 , that (I) (we) last saw the deceased alive on 7/2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Leonard Lister				23B. DATE SIGNED 7/3/72
23C. PHYSICIAN'S NAME (Type) LEONARD LISTER		23D. ADDRESS 7111 PARK HEIGHTS AVENUE		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/4/72		24C. NAME OF CEMETERY or CREMATORY BETH JACOB
24D. LOCATION (City, town, or county) (State) FINKSBURG, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		
25B. NAME OF REGISTRAR Sidney Weinstein		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		

2022-2023

MAY 15, 2023

RECEIVED

2023-2024

2023-2024

2023-2024

2023-2024

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2023-2024

2023-2024

2023-2024

2023-2024

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 06260	
CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. <u>72 06260</u>		1. NAME OF DECEASED (Type or Print) <u>Charles S. Day</u>			
2. DATE AND HOUR OF DEATH <u>7-1-72</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH Home & Hospital</u> <u>35</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Anne Arundel</u>		5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN <u>Pasadena</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>434-A Lake Drive</u>		F. Bayside Beach			
8. DATE OF BIRTH <u>8-22-96</u>		9. AGE (in years last birthday) <u>75</u>		10. Under 1 Yr. <input type="checkbox"/> 11. Under 24 Hrs. <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Day</u>		14. MOTHER'S MAIDEN NAME <u>Lydia S. Props</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>234-01 9056</u>		17. INFORMANT <u>Wife: Mrs. Cora M. Day</u> ADDRESS: <u>434A Lake Drive Bayside Beach Pasadena, Md. 21122</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <u>CHF. Ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASHD</u>					
(B) DUE TO, OR AS A CONSEQUENCE OF: _____					
(C) DUE TO, OR AS A CONSEQUENCE OF: _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>7-1-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>6-23-1972</u> to <u>7-1-1972</u> that (I) (we) last saw the deceased alive on <u>158 P.M. 7-1-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Safadi</u>				23B. DATE SIGNED _____	
23C. PHYSICIAN'S NAME (Type) _____				23D. ADDRESS <u>100 N Broadway</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-5-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Rayville, Balto. Co. Maryland</u>		24E. (State) _____			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1972</u>		25B. NAME OF REGISTRAR <u>Andrew M. ...</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u> ADDRESS: <u>7922 Wise Ave. Dundalk, Md. 21222</u>	

7-1-7

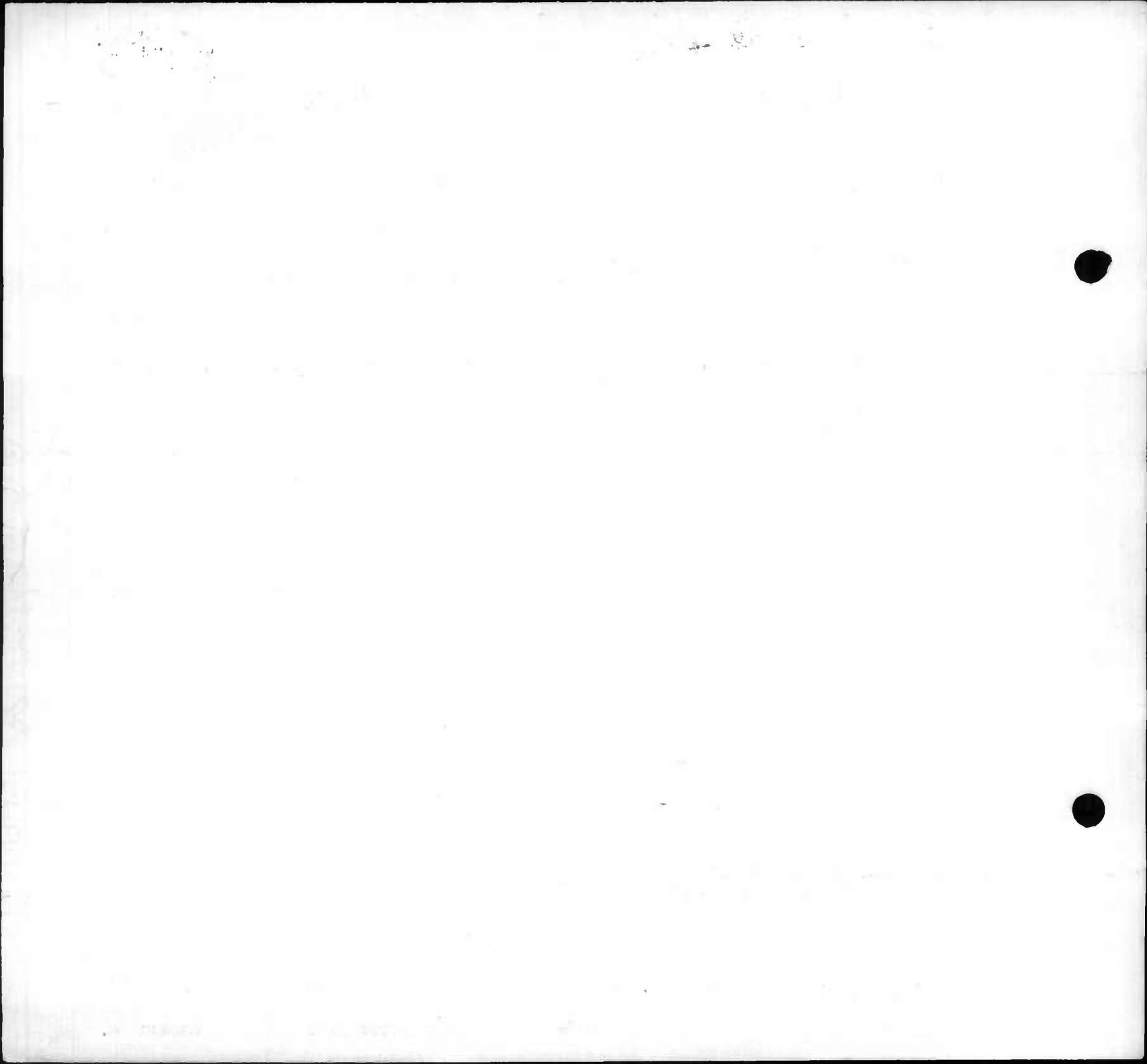
10 11

7-1-7

10 11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

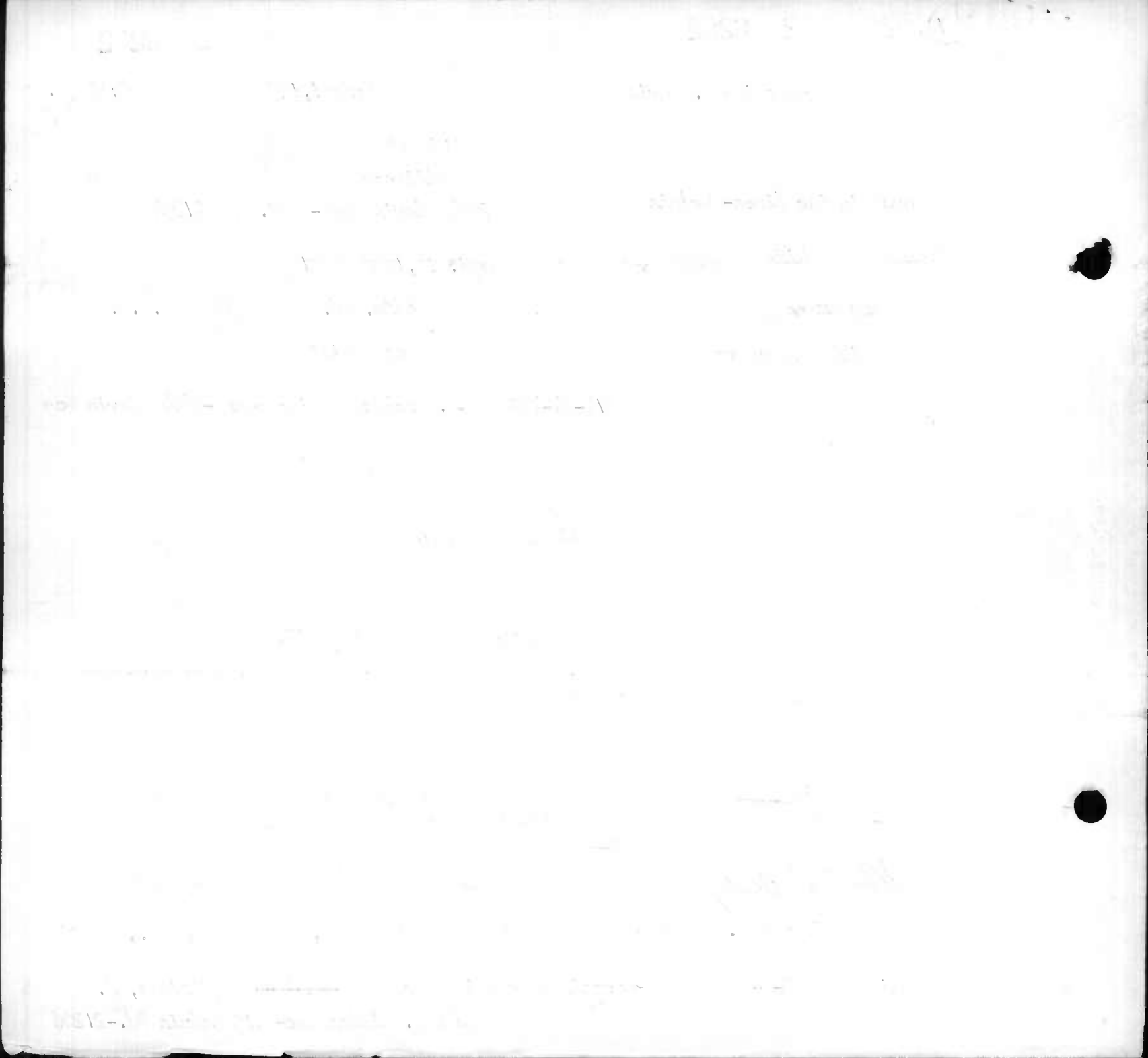
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06261	
E-200		72 06261	
BIRTH NO.		STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) JOHN ECK		2. DATE AND HOUR OF DEATH 7/3/72 5:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2717	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. OF BALTO. 42		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER PIMLICO RACE TRACK 21215	
5. SEX M	6. RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/23 9. AGE (In years last birthday) 49
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROOM		10B. KIND OF BUSINESS OR INDUSTRY D.R. SMALL STARKE	11. BIRTHPLACE (State or foreign country) PA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas J. Eck	
14. MOTHER'S MAIDEN NAME Bernardine E. Laurence		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN	
16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 571.0 I		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(A) IMMEDIATE CAUSE G.I. BLEEDING (ESOPHAGEAL VARICES) DUE TO, OR AS A CONSEQUENCE OF:	
		(B) PORTAL HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF:	
		(C) CHRONIC ALCOHOLISM CAUSING HEPATOCELLULAR DAMAGE	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). POOR NUTRITION			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/29/1972 to 7/2/1972 that (I) (we) last saw the deceased alive on 7/1/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert S. London, M.D.		23B. DATE SIGNED 7/2/72	
23C. PHYSICIAN'S NAME (Type) ROBERT S. LONDON, M.D.		23D. ADDRESS SINAI HOSPITAL OF BALTO. BALTO, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) 7/6/72		24B. DATE	
24C. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery		24D. LOCATION (City, town, or county) Dallastown Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR John Burns Sons	
25C. FUNERAL DIRECTOR		ADDRESS Towson Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

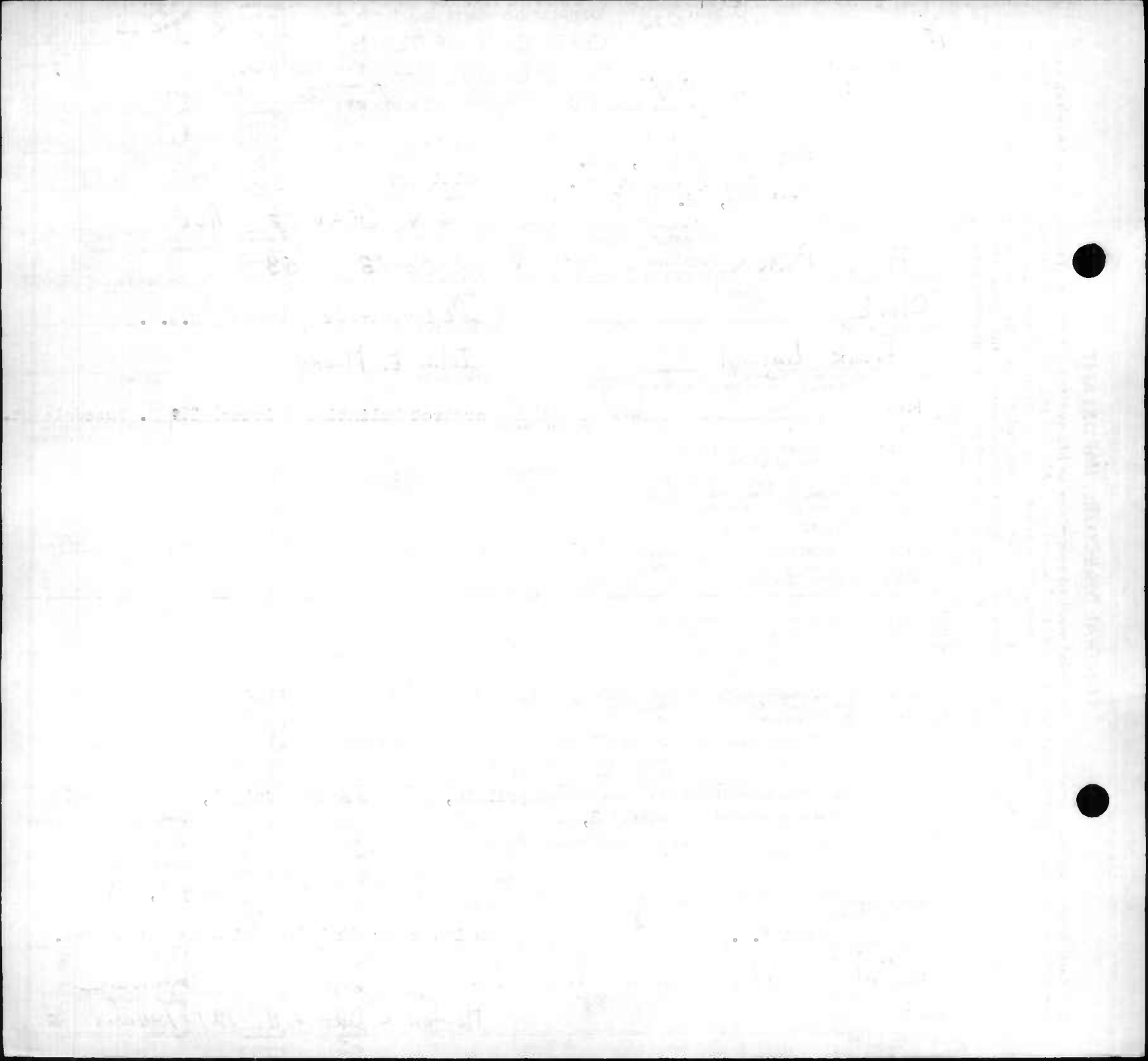
<p>D-120 72 06262</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 06262</p>	
<p>BIRTH NO. STATE OF MARYLAND-DHMH</p> <p>1. NAME OF DECEASED (Type or Print) Katherine C. Davis</p>		<p>2. DATE AND HOUR OF DEATH July 1, 1972 5:25 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) House in the Piner-Belair</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY BALTO</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER 2804 Glavin Way - Apt. D 21234</p>	
<p>5. SEX Female</p>	<p>6. RACE White</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH Sept. 14, 1890</p>
<p>9. AGE (In years last birthday) 81</p>		<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker</p>
<p>11. BIRTHPLACE (State or foreign country) Balto. Md.</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Michael Kaufman</p>		<p>14. MOTHER'S MAIDEN NAME Mary Twist</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 214-54-4236</p>	<p>17. INFORMANT ADDRESS Mrs. Barbara Fleischmann - 2804 Glavin Way</p>
<p>18. 412.1 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Chronic Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (the doctor) attended the deceased from 7/24/1971 to 7/1/1972 that (I) (we) last saw the deceased alive on 6/28/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Albert B. Bradley</p>		<p>23B. DATE SIGNED 7/3/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) Albert B. Bradley</p>		<p>23D. ADDRESS 4900 Belair Road, Baltimore, Md., 21206</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 7-5-72</p>	
<p>24C. NAME OF CEMETERY or CREMATORY Madonridge Memorial Park</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore - Elkridge, Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972</p>		<p>25B. NAME OF FUNERAL DIRECTOR John C. Miller Inc</p>	
<p>25C. FUNERAL DIRECTOR ADDRESS 6415 Belair Rd. - 21206</p>		<p>VS 150-REV. 1/1/68</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06263	
BIRTH NO. 72 06263				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) PRISCILLA ATKINSON		2. DATE AND HOUR OF DEATH 7-3-72 4:30 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215		A. STATE Maryland B. COUNTY 2006	
5. SEX F.		6. RACE BLACK		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 12-03-18		9. AGE (in years last birthday) 53		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DELAWARE, Dover	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank LeGrand		14. MOTHER'S MAIDEN NAME Ida E. Mosley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. 216-10-2529		17. INFORMANT Margaret Valentine (Sister) 2600 N. Rosedale St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 183.01		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Melanotic Carcinoma of the Ovary (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 28, 1972 to July 3, 1972 that (I) (we) last saw the deceased alive on July 3, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Loot M.D.				23B. DATE SIGNED July 3, 1972	
23C. PHYSICIAN'S NAME (Type) Loot M.D.				23D. ADDRESS Provident Hospital 2600 Liberty Height Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72		24C. NAME OF CEMETERY OR CREMATORY Silver Lake Cemetery	
24D. LOCATION Dover, Delaware		24E. CITY, TOWN, OR COUNTY Delaware			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTER Harlan & Dyett F.H.		25C. FUNERAL DIRECTOR ADDRESS 1701 Laurens St.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH WAYNE MATTHEWS

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

39 Provident Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

7

2

1972

6:40 p

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 1513

6. SEX

male

7. RACE

negro

B. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10/6/1962

10. AGE (In years
lost birthday)

9

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2517 Oswego Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Joseph L. Matthews

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

School

15. MOTHER'S MAIDEN NAME

Barbara Spears

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL
SECURITY NO.
-0-

18. INFORMANT

Mr. Rufus Smith

ADDRESS

2517 Oswego Avenue

19.

E910.0

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Drowning

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
pool22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?
Druid Hill Swimming Pool 130422D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 7-2-72

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Accidentally drowned.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-3-72

24A. BURIAL CREMATION,
REMOVAL (Specify)
Burial

24B. DATE

7/6/72

24C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 6 1972

25B. NAME OF REGISTRAR

Sidney Johnston

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H.

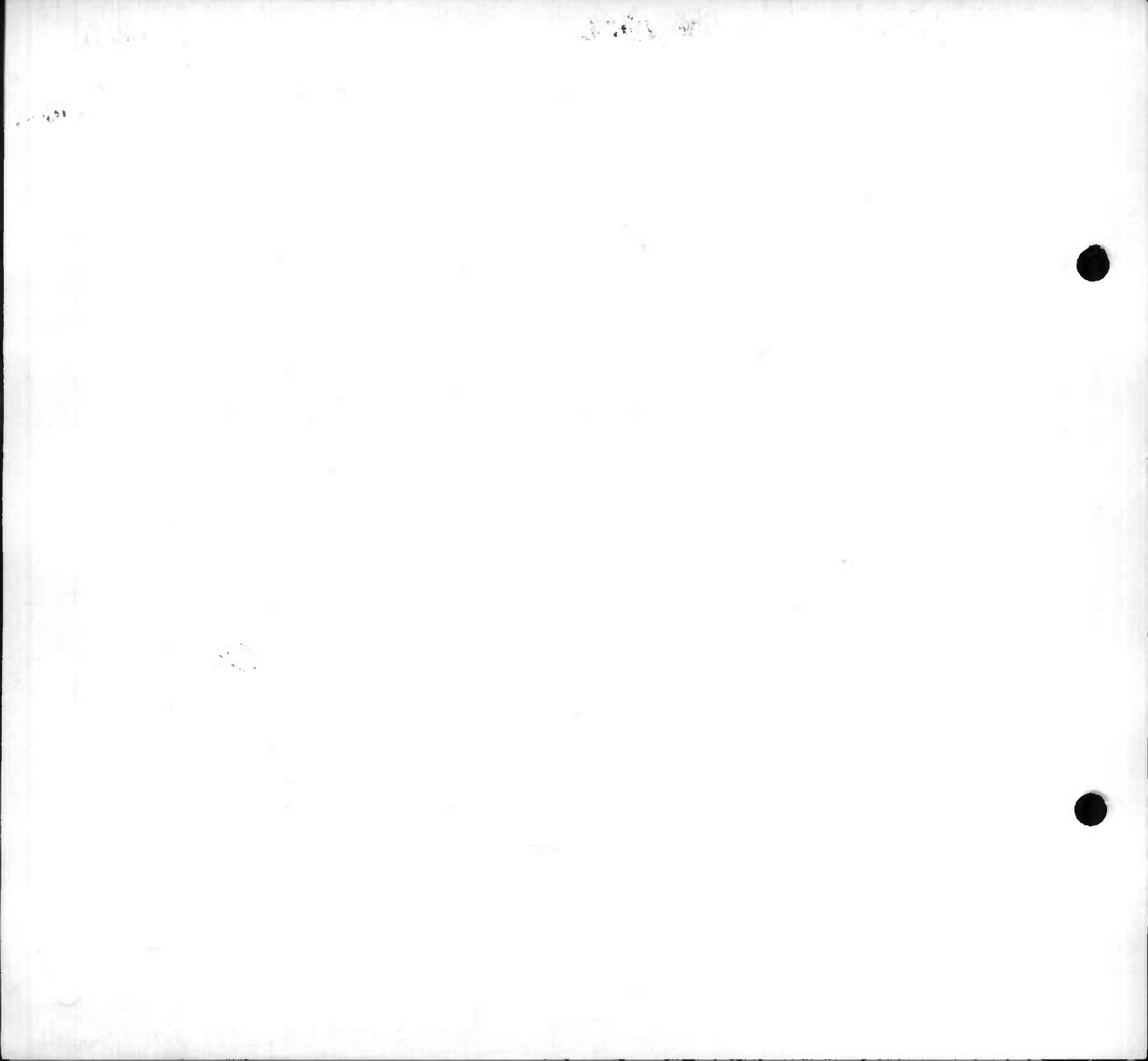
ADDRESS

1701 Laurens St.

WALTER F. FORD

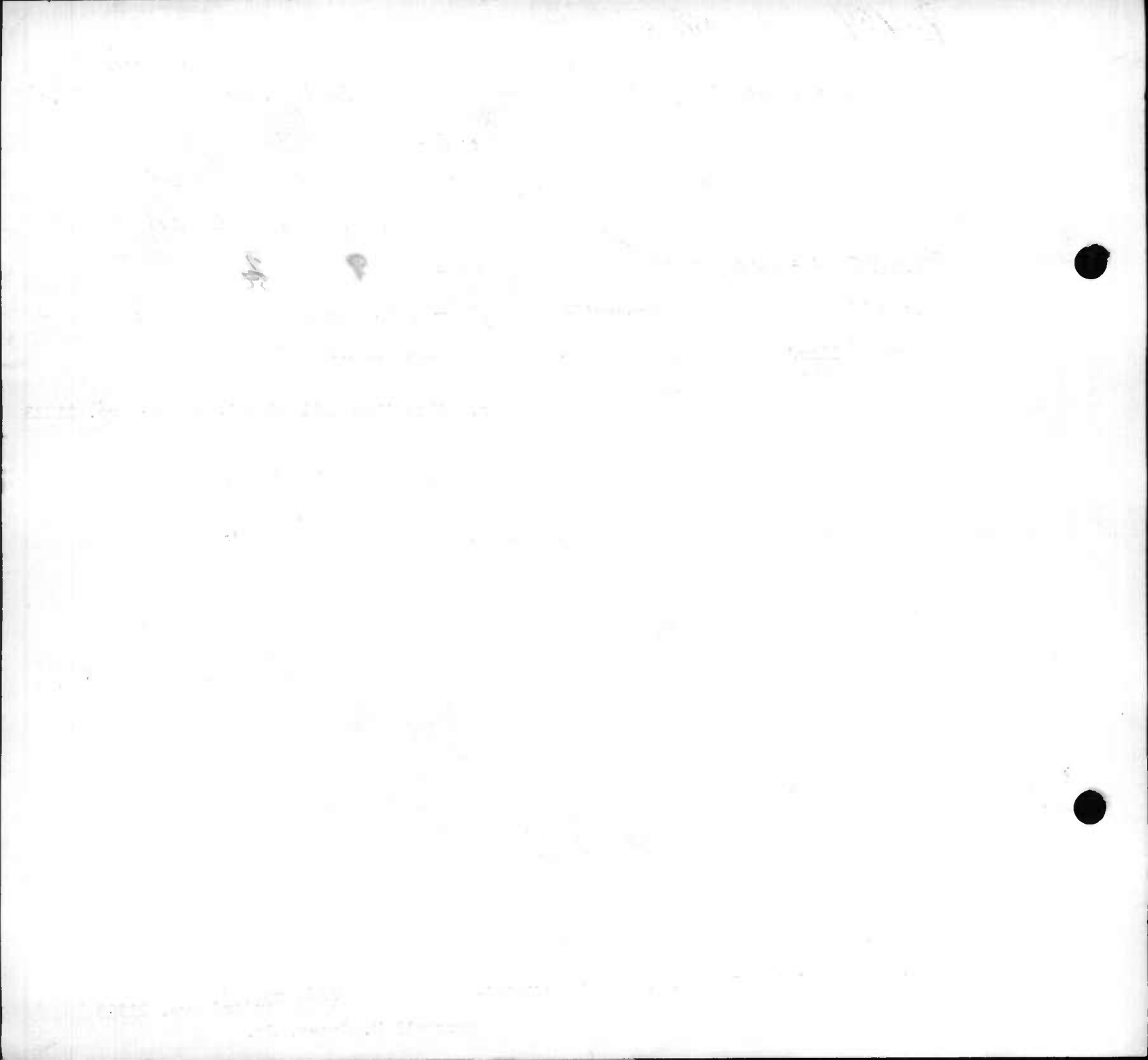
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

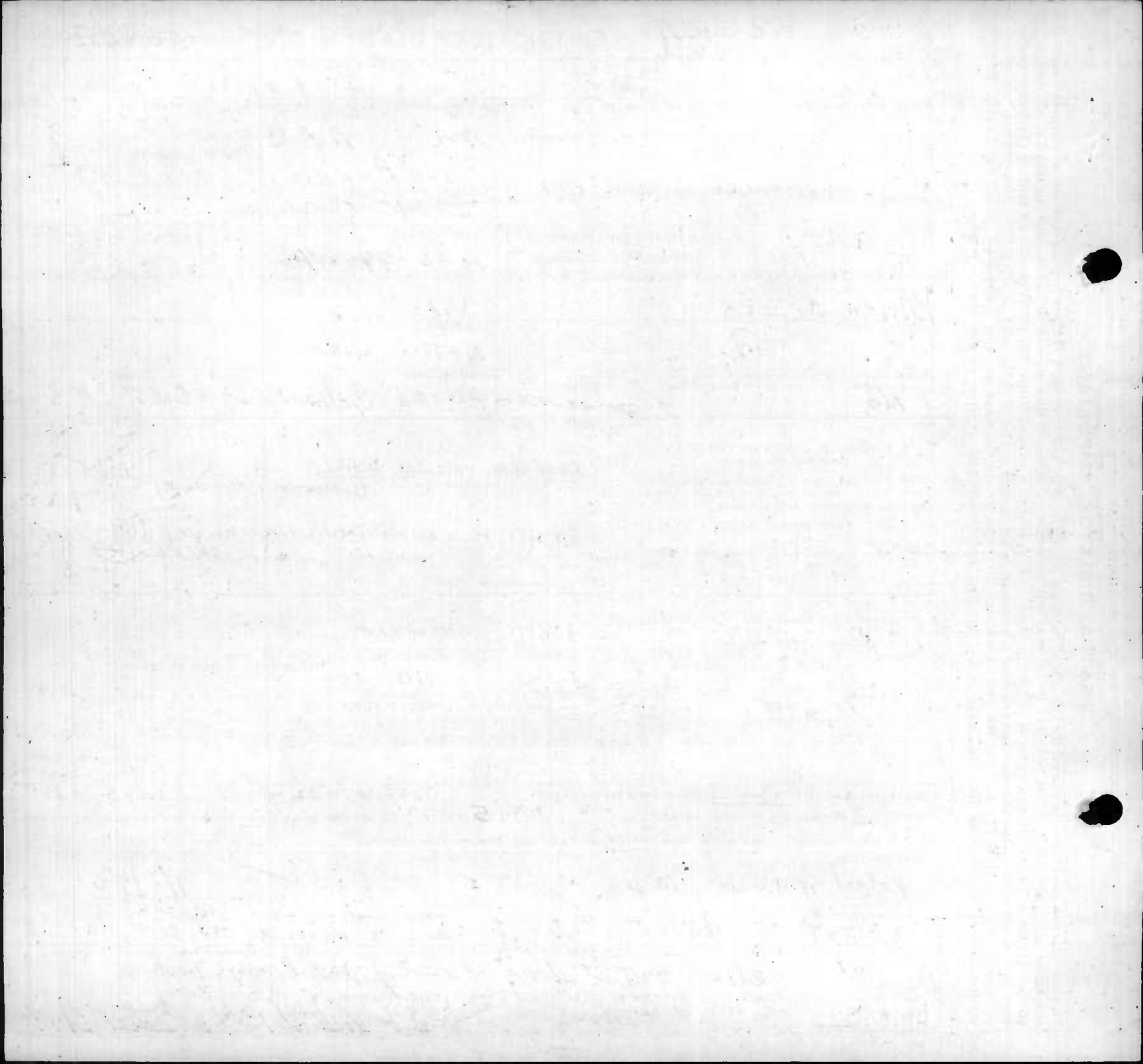
<p>B-424 72 06266</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 06266</p>	
<p>BIRTH STATE OF MARYLAND-DHMH</p>			
<p>1. NAME OF DECEASED (Type or Print) BLACKWELL, ELSIE Lou</p>		<p>2. DATE AND HOUR OF DEATH 7-3-72 10²⁵ P. M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1605</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MD.</p>		<p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER 2408 EDMONDSON AVE</p>			
<p>5. SEX FEMALE</p>	<p>6. RACE NEGRO</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 8-31-09 9. AGE (In years last birthday) 62</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Housewife</p>	
<p>11. BIRTHPLACE (State or foreign country) GEORGIA</p>		<p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>	
<p>13. FATHER'S NAME Jerry Holland</p>		<p>14. MOTHER'S MAIDEN NAME Lucy Roebuck</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p>		<p>16. SOCIAL SECURITY NO.</p>	
		<p>17. INFORMANT ADDRESS Mr. Allen Blackwell 2408 Edmondson Ave. 21223</p>	
<p>18. 250.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Diabetic Acidosis</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) Diabetes DUE TO, OR AS A CONSEQUENCE OF:</p>	
		<p>(C) _____</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) no</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from 7-3-1972 to 7-3-1972 that (I) (we) last saw the deceased alive on 7-3-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (initials) view the body after death.</p>			
<p>23A. SIGNATURE JAWED HAFEZ 2 Siddiqui M.D.</p>		<p>23B. DATE SIGNED 7-3-72</p>	
<p>23C. PHYSICIAN'S NAME (Type) JAWED HAFEZ 2 Siddiqui M.D.</p>		<p>23D. ADDRESS</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 7-7-1972</p>	
<p>24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972</p>		<p>25B. NAME OF REGISTRAR Shirley H. Jones</p>	
		<p>25C. FUNERAL DIRECTOR 1755 Hafford Ave. 21213 Marshall W. Jones, Jr.</p>	



FUNERAL DIRECTOR: IMPORTANT

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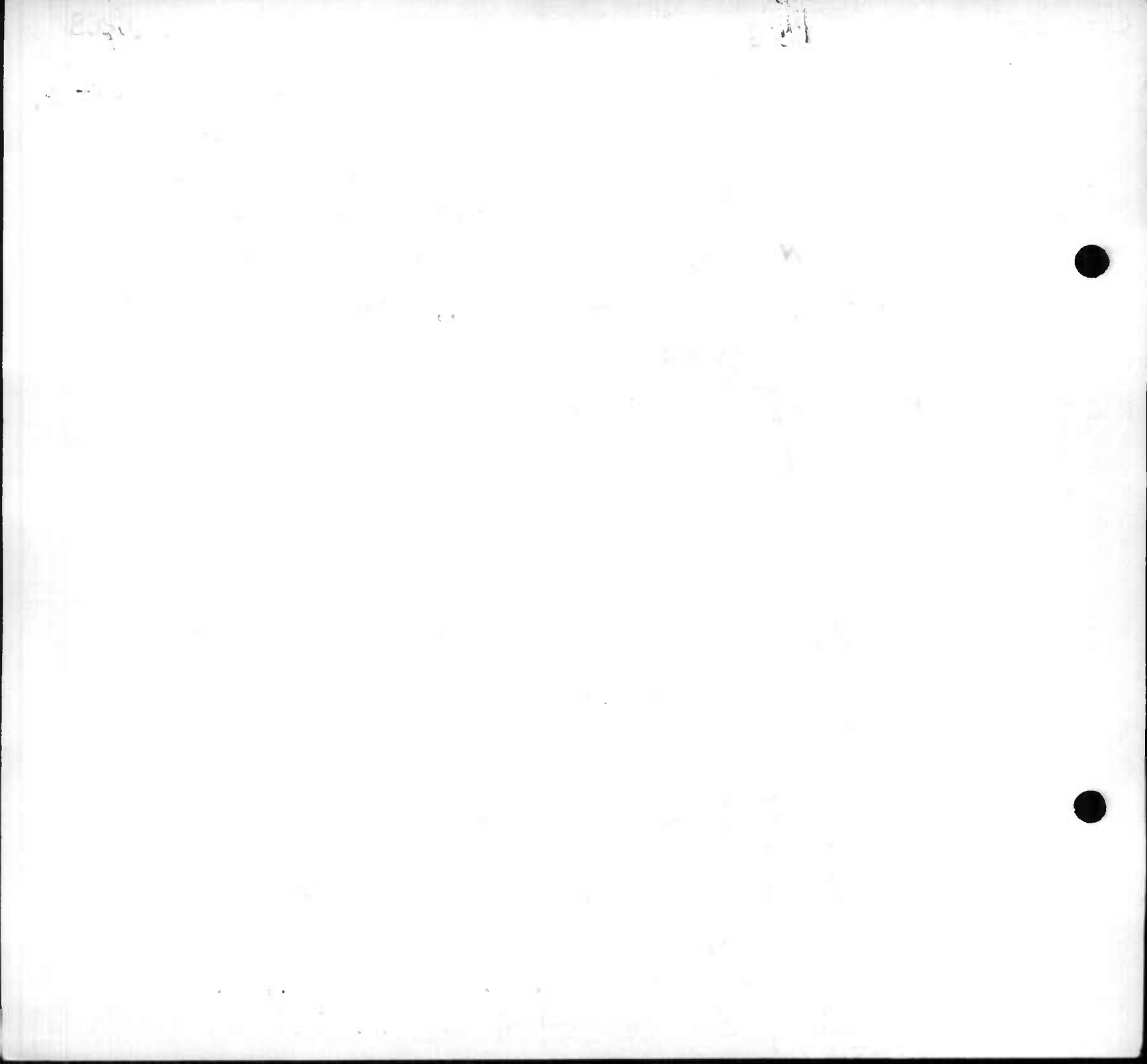
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06267	
G-400 72 06267		CERTIFICATE OF DEATH	
BIRTH NO. STATE OF MARYLAND-DEMH		2. DATE AND HOUR OF DEATH JULY 5, 1972 12:55 A.M.	
1. NAME OF DECEASED (Type or Print) VIRGINIA GALLOWAY		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY A.A.C.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3 SOUTH BALTIMORE GENERAL HOSPITAL		C. CITY OR TOWN GLEN BURNIE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6414 OAK SH.			
5. SEX F.	6. RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-97 9. AGE (in years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KITCHEN HELPER		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME MATTIE JONES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-9762	
		17. INFORMANT ADDRESS ALFRED GALLOWAY 6414 Oak St Glen Burnie	
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). AORTIC ANEURYSM		CAUSE OF DEATH (A) CEREBRAL VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF: (SUBARACHNOID HEMORRHAGE) (B) HYPERTENSIVE + ARTERIOSCLEROTIC CARDIOVASCULAR DUE TO, OR AS A CONSEQUENCE OF: DISEASE (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 10+ YEARS	
MEDICAL CERTIFICATION			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 30 1972 to JULY 5 1972 , that (I) (we) last saw the deceased alive on JULY 5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert J. Bauer, M.D.		23B. DATE SIGNED 7/5/72	
23C. PHYSICIAN'S NAME (Type) ROBERT J. BAUER, M.D.		23D. ADDRESS SOUTH BALT. GENERAL HOSPITAL 3001 S. HANOVER ST., BALT., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/8/72	24C. NAME OF CEMETERY OR CREMATORY mt. Calvary Cemetery A.D. County, Md	24D. LOCATION (City, town, or county) (State) BALTIMORE, MD
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972	25B. NAME OF REGISTRAR Dorothy W. Houston	25C. FUNERAL DIRECTOR Joseph L. Baker ADDRESS 1304 N. Central St	



FUNERAL DIRECTOR: IMPORTANT

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STATE OF MARYLAND-DHMH BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 06268	
BIRTH NO. 72 06268							
1. NAME OF DECEASED (Type or Print) CLAYTON, OLLIE F.				2. DATE AND HOUR OF DEATH 7/4/72 1040 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MARYLAND 46				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND-BALTIMORE 1605 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2324 CALVERTON HTS. AVE.			
5. SEX F	6. RACE A	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-09		9. AGE (in years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Va., USA.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME George Johnson				14. MOTHER'S MAIDEN NAME Nellie Page			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. 212030110		17. INFORMANT Hoyt Clayton		ADDRESS same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I 150X I CAUSE OF DEATH (A) IMMEDIATE CAUSE 3 Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Terminal Carcinoma of Esophagus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 6/16/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Esophagus		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Tammywa ... M.D.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) O. FAMUYIWA M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Audrey W. Houston		25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun Street	



FUNERAL DIRECTOR: IMPORTANT

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STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06269	
BIRTH NO. 72 06269				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Wright, Mande</u>			2. DATE AND HOUR OF DEATH <u>0820 hrs 7/4/72</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u> <u>3601 N. Broadway, Balt, Md 21205</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>08/03/04</u> 9. AGE (In years lost birthday) <u>67</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Geo. Smith</u>			14. MOTHER'S MAIDEN NAME <u>Julia Comadore</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>219309468</u>		17. INFORMANT <u>Chas. Archie Wright</u> ADDRESS <u>same</u>
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Acute ventricular arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>3 hours</u> (B) <u>Acute anterior MI</u> DUE TO, OR AS A CONSEQUENCE OF: <u>(HASCVD)</u> <u>~10 days</u> (C) <u>HBP, Angina (hyperthroidism), MI</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Hyperthyroidism R'd w/ Thyroidectomy</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 years</u>		
19A. DATE OF OPERATION <u>2 none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> 19 <u>72</u> to <u>7/4</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/4</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael Steven Katz, MD</u> DEGREE <u>MD</u>				23B. DATE SIGNED <u>7/4/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael Steven Katz, MD</u>				23D. ADDRESS <u>Apt #804, 550 N. Broadway, Balt, Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-7-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Trinity Mt. Auburn</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. LOCATION (City, town, or county) <u>Calhoun St, Balt, Md</u>		24F. LOCATION (City, town, or county) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>1111 6 1972</u>		25B. NAME OF REGISTRAR <u>Andrew W. Houston</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 Calhoun Street</u>	

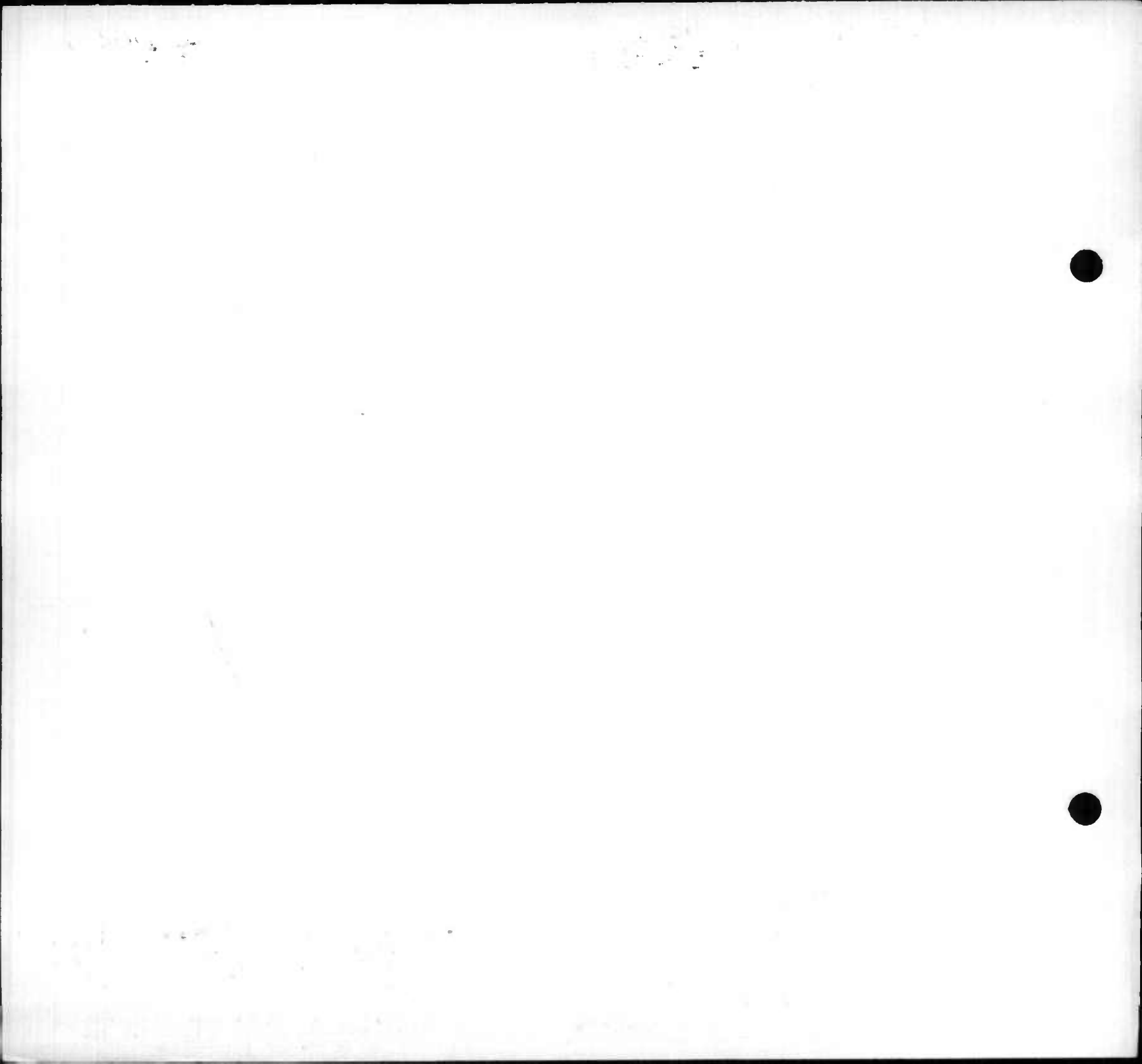
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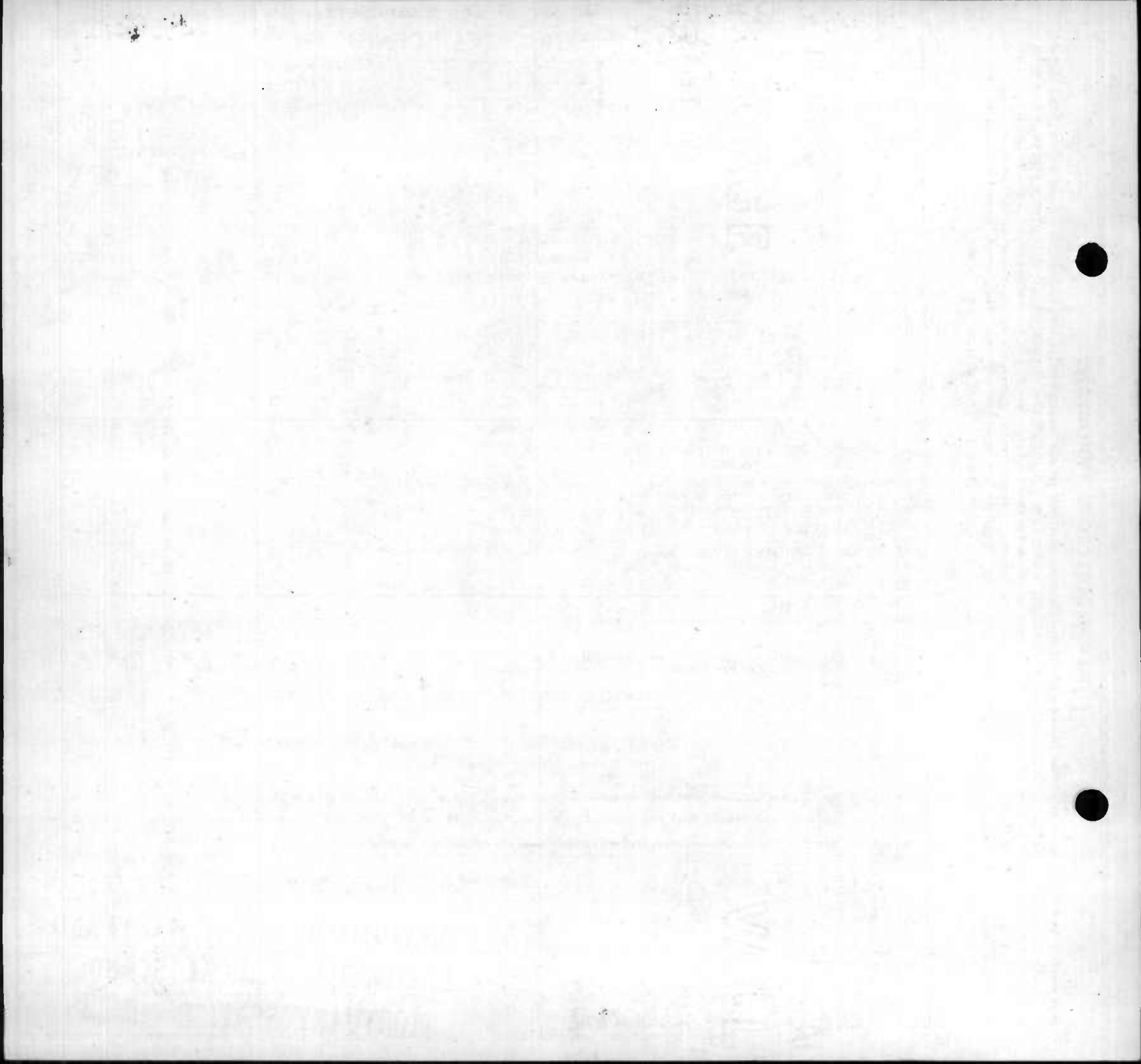
BIRTH NO. STATE OF MARYLAND-DEMH		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 06270	
1. NAME OF DECEASED (Type or Print) BABY BOY VICKERS			2. DATE AND HOUR OF DEATH 6-11-72 3:50am		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSP. 38 BALTIMORE MD.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5307 FERN PARK AV 2802		
5. SEX M	6. RACE Col. N.W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-72	9. AGE (In years last birthday) 4	10. Under 1 Yr. Months 4 Days 4 Hours 4 Min. 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PROVIDENT HOSPITAL Baltimore MD.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Joyce VICKERS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>77611</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE SEVERE HYLAINF MEM- DUE TO, OR AS A CONSEQUENCE OF: BRANE DISEASE</p> <p>(B) Prematurity DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> </div> </div>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION 6-11-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-7-1972 to 6-11-1972 that (I) (we) last saw the deceased alive on 6-11-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rupla A. Eshai (MD)			23B. DATE SIGNED 6-11-1972		
23C. PHYSICIAN'S NAME (Type) RUPLA A. ESHAI			23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL		
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) 6/19/72		24C. NAME of CEMETERY or CREMATORY Anat Bd.		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Frederick Whitson		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06271
W-300 72-08245 72 06271		CERTIFICATE OF DEATH		
BIRTH NO. STATE OF MARYLAND-DEMD				
1. NAME OF DECEASED (Type or Print) BABY BOY WHITE		2. DATE AND HOUR OF DEATH 6/8/1972 5:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE 1763 B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSP. 38		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1050 ARBYLE AV.		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/8/72	9. AGE (In years last birthday) NEWBORN
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Rose zella white.
		17. INFORMANT		ADDRESS
18. 778.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) PREMATURITY ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARDIAC + RESPIRATORY ARREST		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PREMATURITY (B) CARDIAC + RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6/8 19 72 to 6/8 19 72 , that (I) (we) last saw the deceased alive on 6/8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.				
23A. SIGNATURE Fulya O. Nuri		23B. DATE SIGNED 6/8/1972		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Fulya O. Nuri, M.D.		23D. ADDRESS UNIVERSITY BOARD OF MARYLAND		
24A. BURIAL - CREMATION - REMOVAL (Specify)		24B. DATE 6/19/72		24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL		
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Dr. [Signature]		25C. FUNERAL SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 1.2em; margin: 0;">72-06272</p> <p style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; margin: 0;">72-06272</p>		<p style="margin: 0;">REG. NO. 72 06272</p>	
<p style="text-align: center; font-weight: bold;">BIRTH NO. STATE OF MARYLAND - DEATH</p>			
<p>1. NAME OF DECEASED (Type or Print) <i>GIRL</i> The Baby of Shirley Stith</p>		<p>2. DATE AND HOUR OF DEATH January 2, 1972 9:45 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md.. 21215</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2001 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1927 Mulberry St..</p>	
<p>5. SEX Female</p>	<p>6. RACE Negro</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 1-2-72</p>
<p>9. AGE (In years last birthday)</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>	<p>11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>
<p>13. FATHER'S NAME</p>		<p>14. MOTHER'S MAIDEN NAME Shirley Stith</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	<p>17. INFORMANT Shirley Stith ADDRESS 1927 Mulberry St.</p>
<p>18. 72691 CAUSE OF DEATH</p> <p style="text-align: center;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from January 2, 1972 to January 2, 1972 that (I) (we) last saw the deceased alive on January 2, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>[Signature]</i></p>		<p>23B. DATE SIGNED June 16, 1972</p>	
<p>23C. PHYSICIAN'S NAME (Type) Santos M.D.</p>		<p>23D. ADDRESS Provident Hospital 2600 Liberty Height Ave.</p>	
<p>24A. BURIAL, CREMATION, 24B. DATE REMOVAL (Specify) 6/20/72</p>		<p>24C. NAME of CEMETERY or CREMATOR Anatomy Board of Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972</p>		<p>25B. NAME OF REGISTRAR <i>[Signature]</i></p>	

ANATOMY BOARD OF MARYLAND
UNIVERSITY OF MARYLAND MEDICAL SCHOOL
MORTUARY SERVICE - BCMD

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

1-2-22



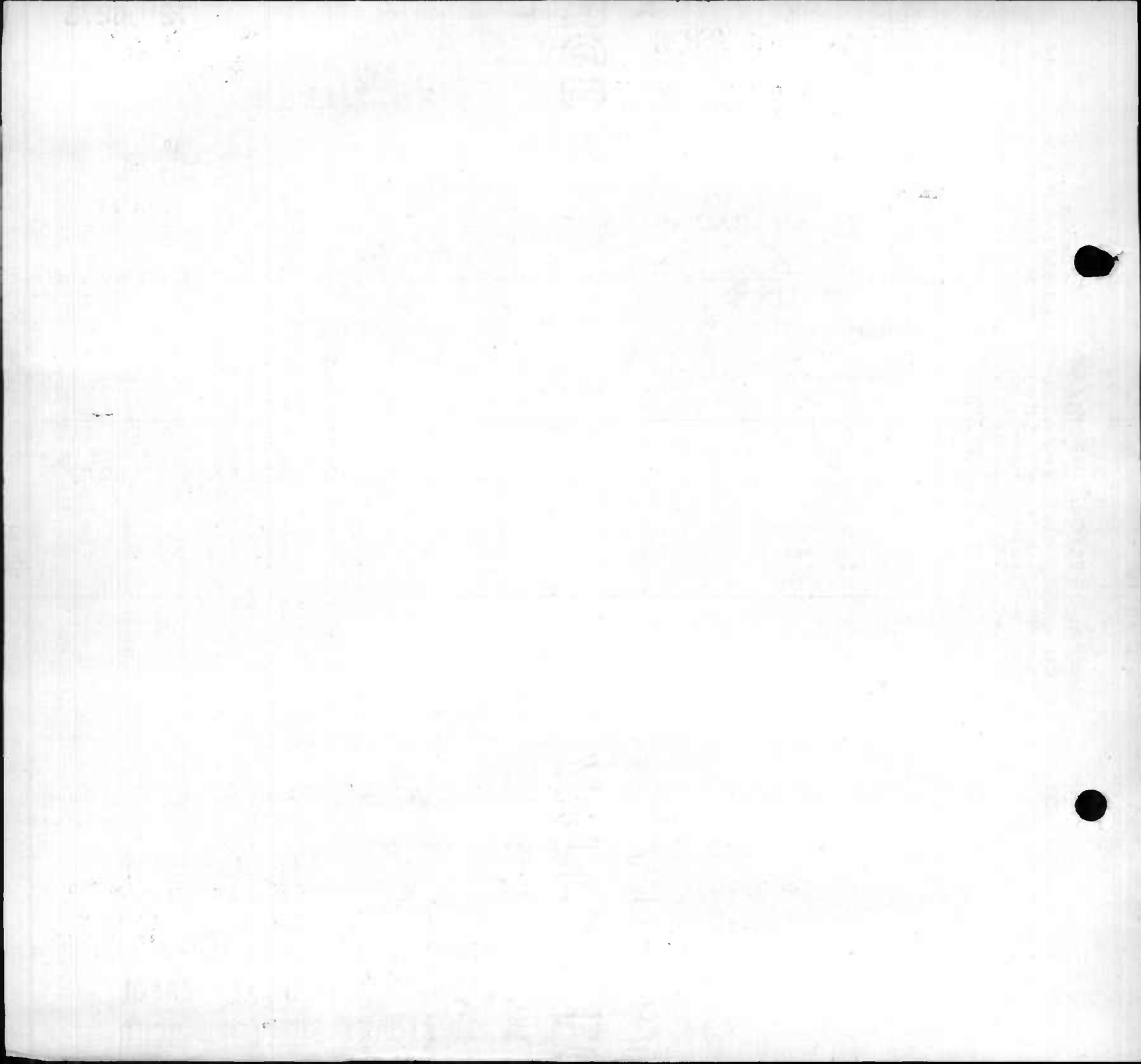
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constraint

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-5307-13272 06273		BALTIMORE CITY HEALTH DEPT.		72 06273	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BABY BOY SNOWDON		6/19/72 7AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
44 UNION Memorial Hosp.		Md.		906	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1620 E. 28th St.		21218	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
m	N	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/18/72		8 6
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Marshall AERSAL Jackson		R Honda JEAN SNOWDEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 77611 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		RESPIRATORY, CARDIAC ARREST ~ 9 HRS	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:		HYALINE MEMBRANE DISEASE PREMATURITY	
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/18/72 1972 to 6/19/72 1972, that (I) (we) last saw the deceased alive on 6/19/72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		HOUSE STAFF	
Tyronne S. Cusack MD		6/19/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
TYRONE S. CUSACK MD					
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATION	
		6/19/72		ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 6 1972		Tyronne S. Cusack MD		UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



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C-520

72 06274

BALTIMORE CITY HEALTH DEPARTMENT

72 06274

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEMH

REG. NO.

1. NAME OF DECEASED (Type or Print) Joseph J. Cammage				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 6 17, 1972 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4403 Colborne Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour 6 17, 1972 9:45 PM M.			
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2874	
9. DATE OF BIRTH		10. AGE (In years last birthday) 54		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. E 955 0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH Carbon monoxide poisoning.			
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) garage			
22D. TIME OF INJURY (APPROX.) 6 17,72 ?				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? garage, rear of 4403 Colbourne Ave.				22F. HOW DID INJURY OCCUR? inhaled automobile exhaust fumes.			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.				Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE 6/19/72			
24C. NAME OF CEMETERY or CREMATION				24D. LOCATION (City, town, etc.)			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972				25B. NAME OF REGISTRAR ANAT. B D			
25C. FUNERAL DIRECTOR				25D. ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD			

8550

THE UNIVERSITY OF CHICAGO

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WHITE PAPER

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

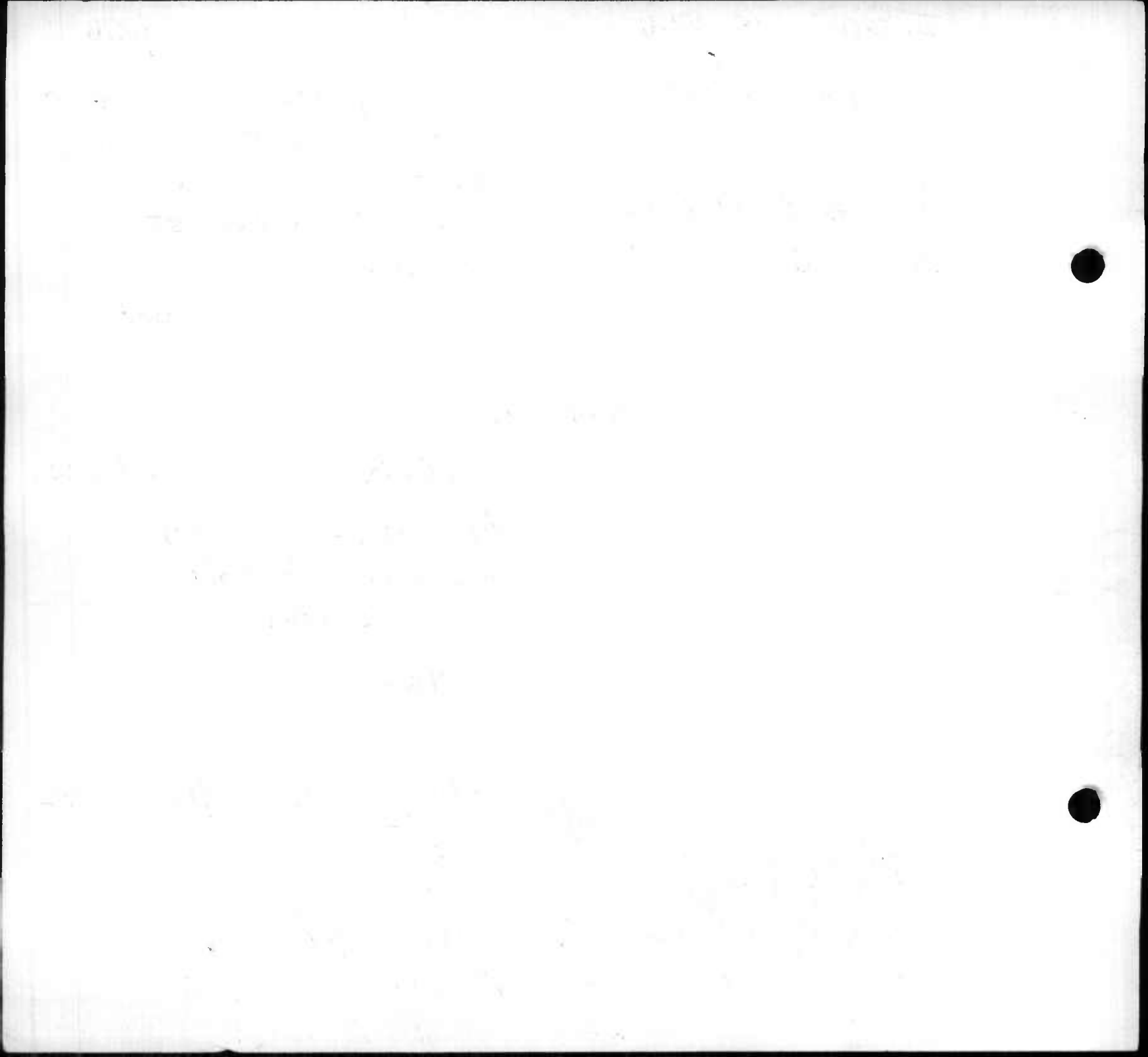
<p>P-300 72 06275</p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 72 06275</p>			
<p>BIRTH NO. STATE OF MARYLAND-DHMH</p> <p>1. NAME OF DECEASED (Type or Print) Mattie Pitt</p>		<p>2. DATE AND HOUR OF DEATH June 20, 1972 9 A.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Ardleigh Nursing Home</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence below admission) A. STATE Baltimore B. COUNTY 1102</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3313 Poplar Street</p>	
<p>5. SEX female</p>	<p>6. RACE white</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 11/4/1892</p>
<p>9. AGE (In years last birthday) 79</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>	<p>11. BIRTHPLACE (State or foreign country)</p>
<p>12. CITIZEN OF WHAT COUNTRY?</p>		<p>13. FATHER'S NAME</p>	
<p>14. MOTHER'S MAIDEN NAME</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>	
<p>16. SOCIAL SECURITY NO. 213-18-7434</p>		<p>17. INFORMANT ADDRESS</p>	
<p>18. 4327 I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>(A) IMMEDIATE CAUSE A S V D Chronic Brain DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Syndrome due to Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: 10 yrs.</p> <p>(C) _____</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from September 22, 1971 to June 20, 1972 19 that (I) (we) last saw the deceased alive on June 14, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.</p>			
<p>23A. SIGNATURE Lloyd E. Saylor, M.D.</p>		<p>23B. DATE SIGNED June 20, 1972</p>	
<p>23C. PHYSICIAN'S NAME (Type) Dr. Lloyd Saylor</p>		<p>23D. ADDRESS 3902 Greenmount Avenue 21218</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p>		<p>24B. DATE 6/20/72</p>	
<p>24C. NAME OF CEMETERY OR CREMATOR Anatomy Board of Maryland</p>		<p>24D. BOARD OF MORTUARY SERVICE - BCHD</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972</p>		<p>25B. NAME OF REGISTRAR Andrew...</p>	
<p>25C. FUNERAL DIRECTOR</p>		<p>25D. ADDRESS</p>	

5/10/70

517. Cathedral St.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



S-300 72 06277

BALTIMORE CITY HEALTH DEPARTMENT

72 06277

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) WILLIAM T. SCOTT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour June 2, 1972 8:35 P.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 66		E. STREET AND NUMBER 632 Dover Street	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20C. AUTOPSY? (Yes or No) no		21. DATE OF OPERATION	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> (M.D.) EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/3/72			
24A. BURIAL (CREMATION) REMOVAL (Specify)		24B. DATE 6/23/72	
24C. NAME OF CEMETERY OR CREMATOR Anatomy Board		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR <i>Anthony...</i>	
25C. FUNERAL DIRECTOR		25D. ADDRESS	

ACADEMIC YEAR 1960-61

WED. 11/11/60

VALLEY SAT. 11/13/60

11/11/60

11/12/60

11/13/60

11/14/60

11/15/60

11/16/60

11/17/60

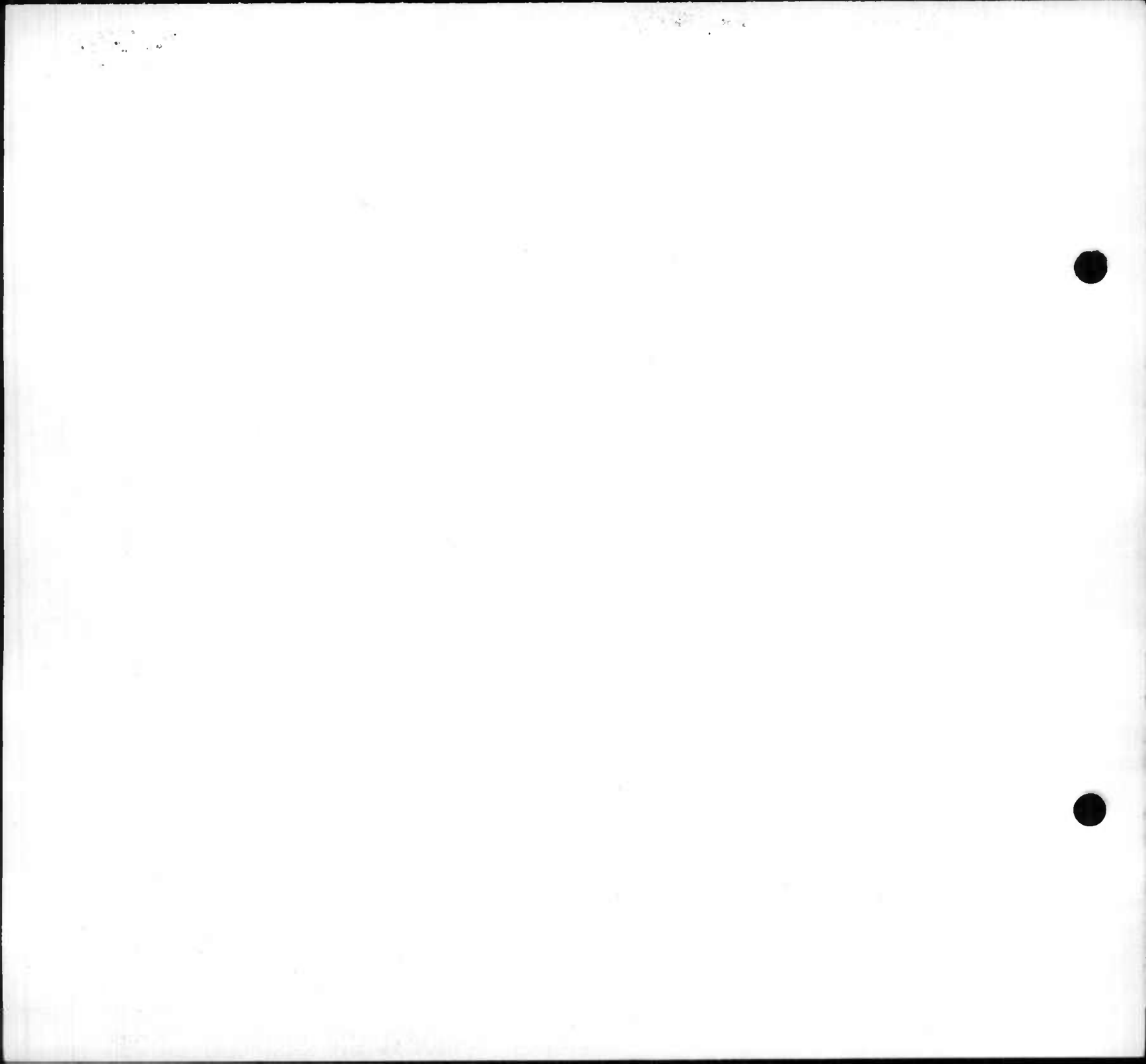
11/18/60

11/19/60

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120 72 06278		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06278	
STATE OF MARYLAND-DEMH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Davis, Thornwell</u>		2. DATE AND HOUR OF DEATH <u>6/25/72</u> <u>9:10 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ. of Md Hosp</u>		A. STATE <u>Md.</u> B. COUNTY <u>1701</u>		C. CITY OR TOWN <u>Balt.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>416 N. Greene St</u>					
5. SEX <u>M</u>	6. RACE <u>N.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>60</u>	9. AGE (In years last birthday) <u>60</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>PH.</u> ADDRESS	
18. <u>4124145710</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>min</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Severe ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>YRS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>Chronic alcoholism + cirrhosis</u>		<u>YRS.</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> <u>5/5</u> 19 <u>72</u> to <u>6/25</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>6/24</u> <u>5/5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>K.W. Mellinger MD</u>		23B. DATE SIGNED <u>6/25/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Richard W. Mellinger MD</u>		23D. ADDRESS <u>Univ. of Md Hosp</u>			
24A. BURIAL - CREMATION REMOVAL (Specify) <u>4/28/72 Anatomy</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>	
24D. LOCATION (City, town, or county) <u>UNIVERSITY MEDICAL SCHOOL</u>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1972</u>		25B. NAME OF REGISTRAR <u>Johnny Whitson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>	

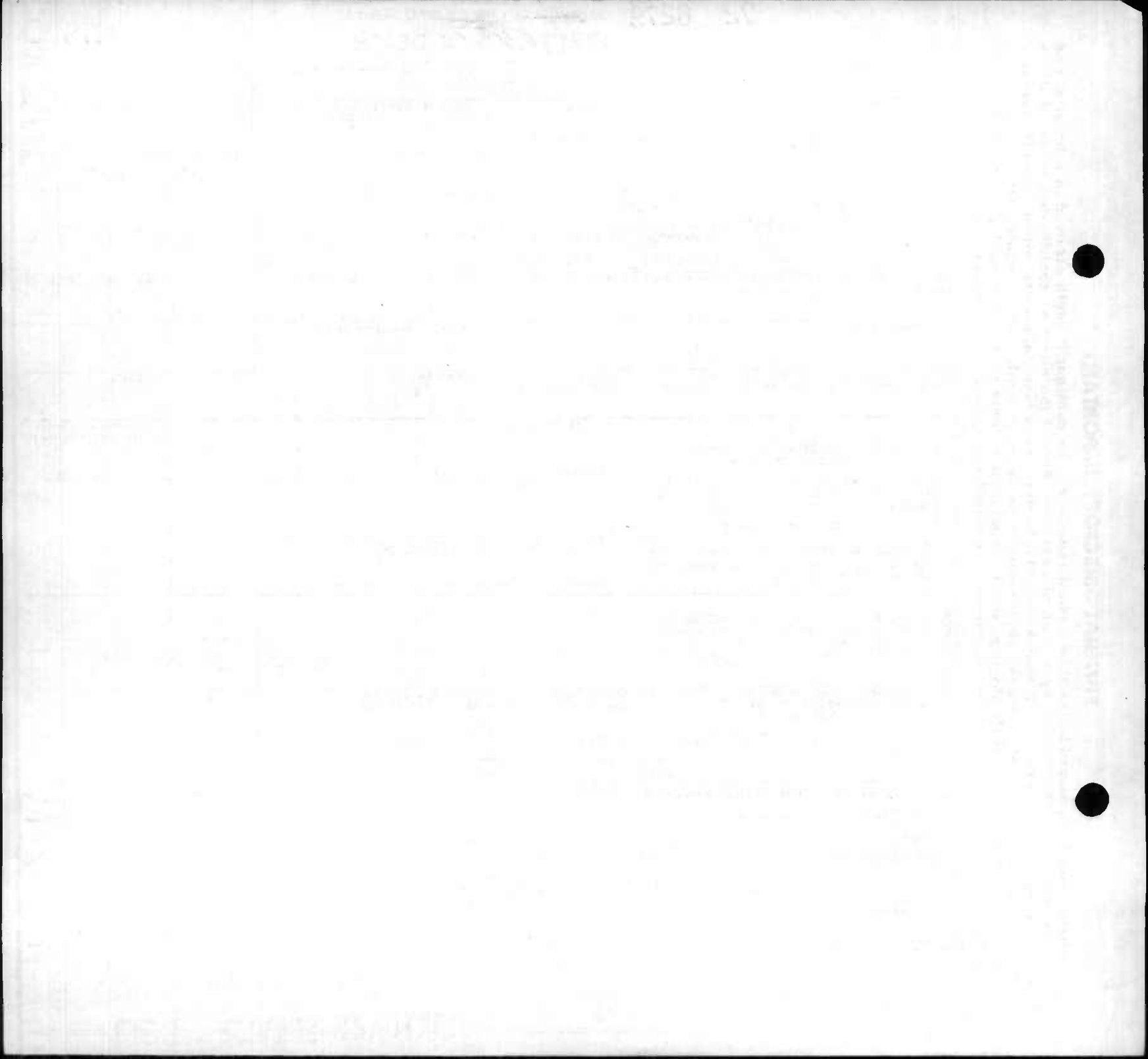


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72-06279		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72-06279	
STATE OF MARYLAND - DHMH			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Harvey E. Hower		2. DATE AND HOUR OF DEATH 6/21/72 1:22 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY CITY			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. Gen. Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN CITY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6/20/05 9. AGE (in years last birthday) 67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn PA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chart ADDRESS	
18. 412.41		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-pulm. catastrophe			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary edema			
		(C) ASCVD			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		COPD	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/20/72 19 72 to 6/21/72 19 72 that (I) (we) last saw the deceased alive on 6/21/72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Samaras MD		DEGREE		23B. DATE SIGNED 6/21/72	
23C. PHYSICIAN'S NAME (Type) G.C. SAMARAS MD		DEGREE		23D. ADDRESS	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 6/28/72		24C. NAME of CEMETERY or CREMATORY Anatomy	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR John J. Wilson		25C. FUNERAL DIRECTOR ADDRESS	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

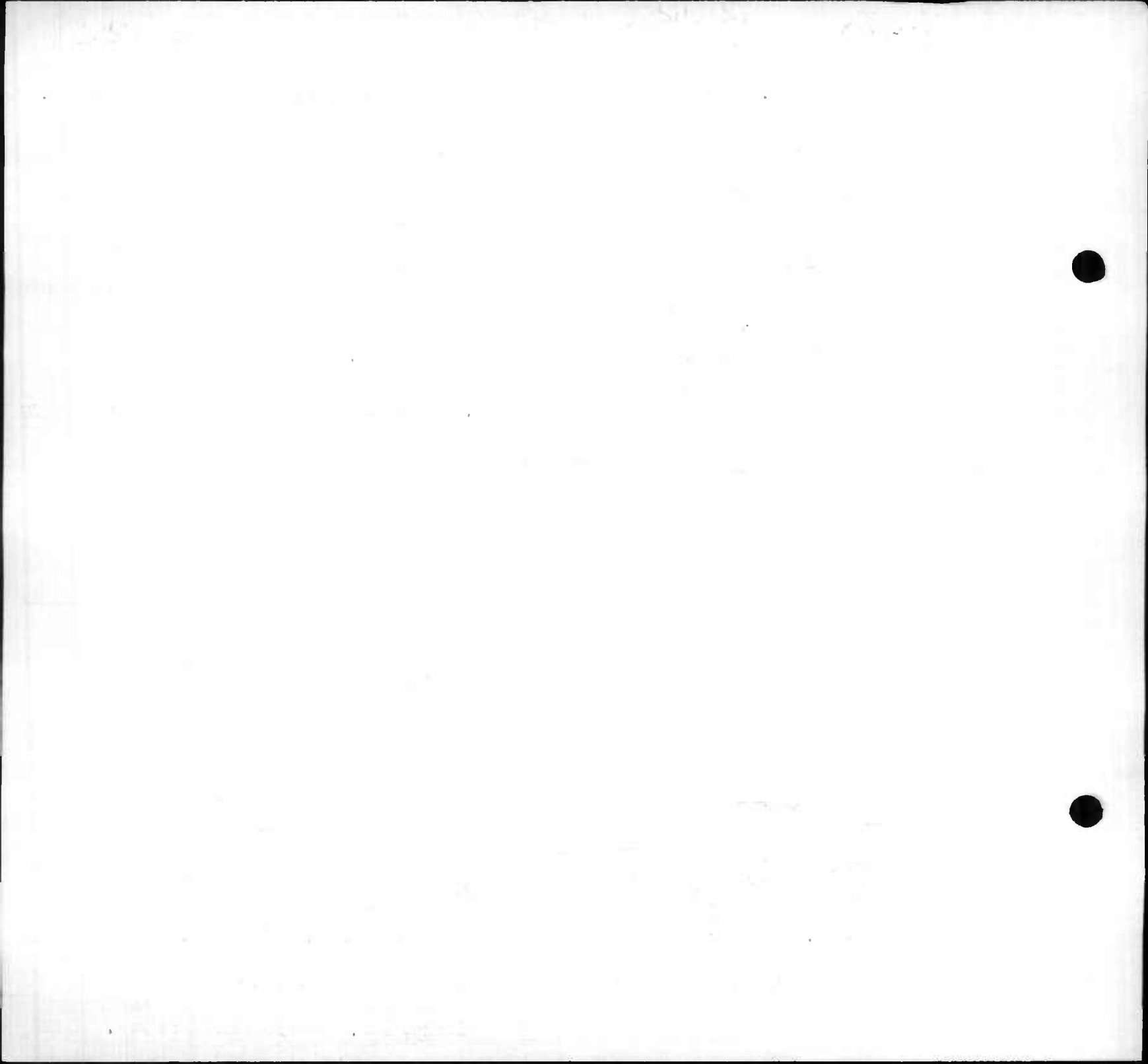
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MBJ 1		72-06280		BALTIMORE CITY HEALTH DEPARTMENT		72-06280	
M-254				72-06280		REG. NO.	
BIRTH STATE OF MARYLAND-DHMH				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		MC NULTY, BEATRICE MARIE		2. DATE AND HOUR OF DEATH		JULY 4, 1972 6:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		6300	
40 ST AGNES HOSPITAL				MARYLAND			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				ELLICOTT CITY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				3618 UNDEROAK DRIVE			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FEMALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12 09 22	49	HOUSEWIFE	MARYLAND	U S A
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
WILLIAM KIMMERLY		BEATRICE CHURCH		NO		214-18-0362	
				17. INFORMANT		ADDRESS	
				CATON AVES., BALTO MD 21229		ST AGNES HOSPITAL RECORDS, WILKENS &	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		SEVERE BLEEDING FROM DUODENUM DUE TO		1 day			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:					
		EROSION OF CA. PANCREAS.					
		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C) DUE TO, OR AS A CONSEQUENCE OF:					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
7/4/72	EXPLORATION	NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?					
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (X) (this hospital) attended the deceased from JULY 4, 1972 to JULY 4, 1972. that (X) (we) last saw the deceased alive on JULY 4, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED					
J. Kimmerly		7/4/72					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
JESADA WILKENS		ST AGNES HOSPITAL					
		WILKENS & CATON AVES BALTO MD 21229					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)				
BURIAL	07/07/72	DRUID RIDGE	PIKESVILLE - BALTO. CO. - MD.				
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	25D. ADDRESS				
JUL 6 1972	J. Kimmerly	HARRY WITZKE FUNERAL HOME	ELLICOTT CITY MARYLAND 21043				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BIRTH NO. <u>J-520</u> STATE OF MARYLAND-DEMT</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p>		<p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 06281</p>	
<p>1. NAME OF DECEASED (Type or Print) LeRoy E. Jones</p>				<p>2. DATE AND HOUR OF DEATH July 4, 1972 9:30 P.M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 517 Kingston Road</p>				<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2854</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 517 Kingston Road</p>			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/11	9. AGE (In years last birthday) 61	<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Owner		10B. KIND OF BUSINESS OR INDUSTRY Sunpaper		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME late Edgar Allan Jones				14. MOTHER'S MAIDEN NAME late Eva W. (Harris)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-10-3743		17. INFORMANT ADDRESS A. Katharine Jones 517 Kingston Road 21229			
<p>18. 4-12-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Atherosclerotic Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)</p>				<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden</p>			
				<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<p>22. I certify that (I) (this hospital) attended the deceased from 10-26 19 72 to 7-4 19 72 that (I) (we) last saw the deceased alive on 7-3 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>							
23A. SIGNATURE John F. Schaefer MD				23B. DATE SIGNED July 5 1972		23C. PHYSICIAN'S NAME (Type) John F. Schaefer	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Lidney Ingham		25C. FUNERAL DIRECTOR Witzke, Inc.		25D. ADDRESS 1630 Edmondson Ave. 21228	



38-27-67 1

BIRTH NO. STATE OF MARYLAND-DEME				72 06282		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06282	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
John Skunda (JOHN SKUNDA)				July 3, 1972 6:20 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY					
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland 2605					
				C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
				Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER					
				431 Hornel Street 21224					
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		Caucasian		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Mar. 12, 1894		78	
								11. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired				Beth. Steel Co.		Czechoslovakia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
John Skunda				Susan ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				79-10-3733		4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				Cardiac Arrest					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) recent myocardial infarction					
				(C)					
II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				5 minutes					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				no					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 6/27/72 to 7/3/72 that (I) (we) last saw the deceased alive on 7/3/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Philip L. Smith				7/3/72					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
PHILIP L. SMITH				4940 Eastern Avenue Baltimore City Hospital Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		7-6-72		St. Stanislaus Cem.		6515 Boston Ave., Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 6 1972		Sidney Johnson		Charles S. Spiles		6224 Eastern Ave. Balto., 21224, Md.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO.

72 06283

BIRTH NO. 72 06283

1. NAME OF DECEASED
(Type or Print)

Robert Lawson

2. DATE AND HOUR OF DEATH

7/1/72

4.30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1029 W. Clay Street

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Oct. 5, 1924

9. AGE (In years
last birthday)

47

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Sumter S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willie Lawson

14. MOTHER'S MAIDEN NAME

Maybelle Witherspoon

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

BCH-RECORDS

ADDRESS

4940 Eastern Avenue

Baltimore, Maryland 21224

18. 41221

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Chronic Renal Failure 5 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Hypertension

more than
5 years

(C) A.S.C.U.D.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/12 1972 to 7/1 1972,
that (I) (we) lost saw the deceased alive on 7/1 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michelle Codina M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/1/72

23C. PHYSICIAN'S
NAME (Type)

Michelle Codina M.D.

23D. ADDRESS

B. C. 14

4940 Eastern Avenue

Baltimore, Maryland 21224

24A. BURIAL-CREATION,
REMOVAL (Specify)

24B. DATE

7/7/72

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Baltimore Md.

1 City, town, or county

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 6 1972

25B. NAME OF REGISTRAR

Audrey Ingham

25C. FUNERAL DIRECTOR

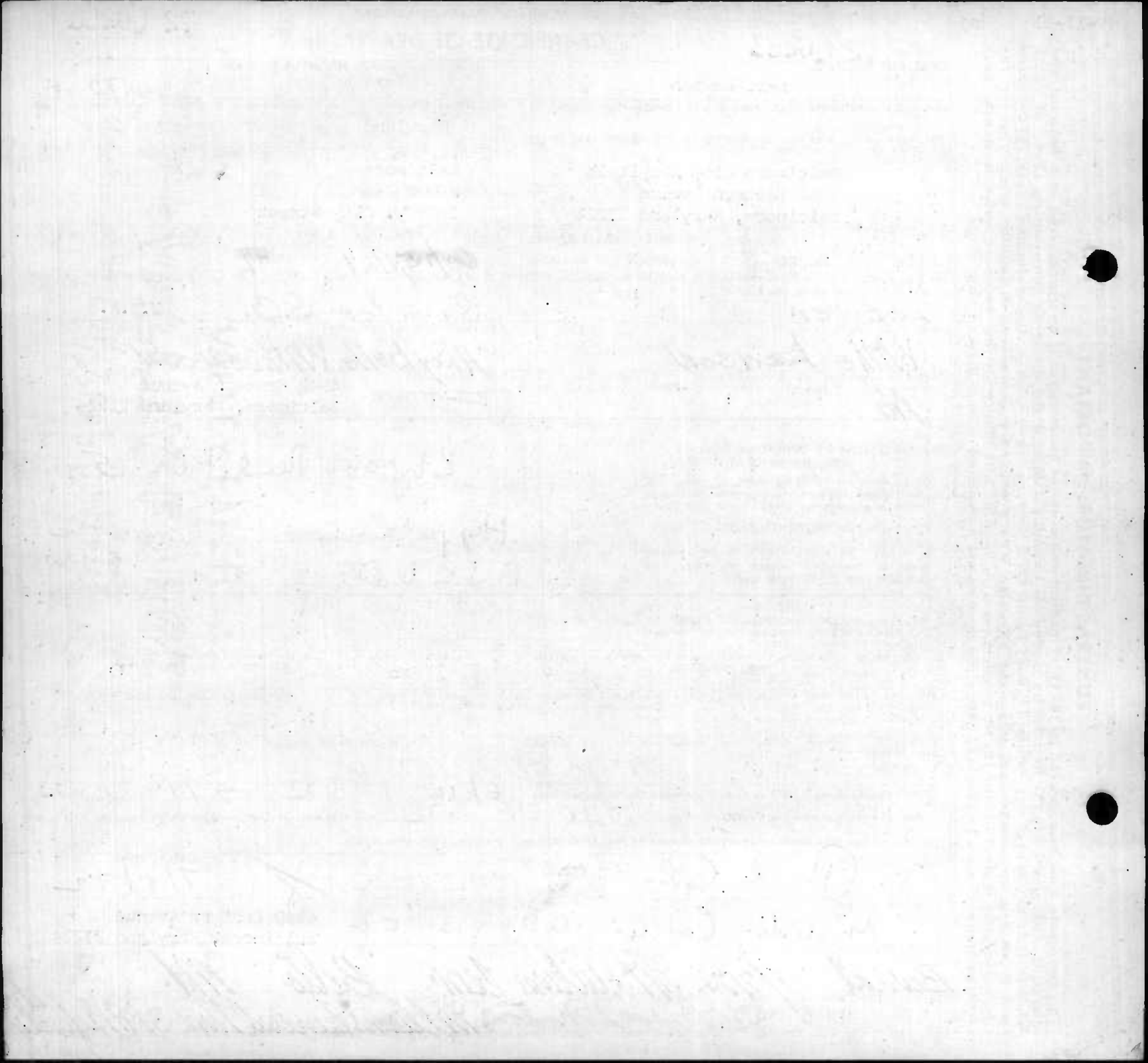
Williams Funeral Home

ADDRESS

3191 Schaefer

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



MAK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72-06284

BIRTH NO.

72 06284

1. NAME OF DECEASED

(Type or Print)

CHRISTIAN, WESLEY WILLIAM

2. DATE AND HOUR OF DEATH

JULY 5, 1972 9:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

40 ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

102 NORTH DENISON ST 21229

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5/7/03

9. AGE (in years last birthday)

69

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MINISTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

NED CHRISTIAN

14. MOTHER'S MAIDEN NAME

Mary Watson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

217 01 6926

17. INFORMANT

BALTIMORE MARYLAND 21229
ST AGNES HOSPITAL CATON & WILKENS AVE

ADDRESS

18. 430.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE CVA (Subarachnoid Hemorrhage)

DUE TO, OR AS A CONSEQUENCE OF

34 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

ASCVD, SEPTICEMIA (GRAM NEG)

19A. DATE OF OPERATION

6/22

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

CAROTID ARTERIOGRAM

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from JUNE 01 1972 to JULY 5 1972, that (IX) (we) last saw the deceased alive on JULY 5 1972 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXXXX) view the body after death.

23A. SIGNATURE

Robert W. Ashmore MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

7/5/72

23C. PHYSICIAN'S NAME (Type)

ROBERT W. ASHMORE M.D.

23D. ADDRESS

BALTIMORE MARYLAND 21229
ST AGNES HOSPITAL CATON & WILKENS AVE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-10-72

24C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION

(City, town, or county)

Balto., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 6 1972

25B. NAME OF REGISTRAR

Sidney H. Weston

25C. FUNERAL DIRECTOR

Wm C March 928 E North Ave.

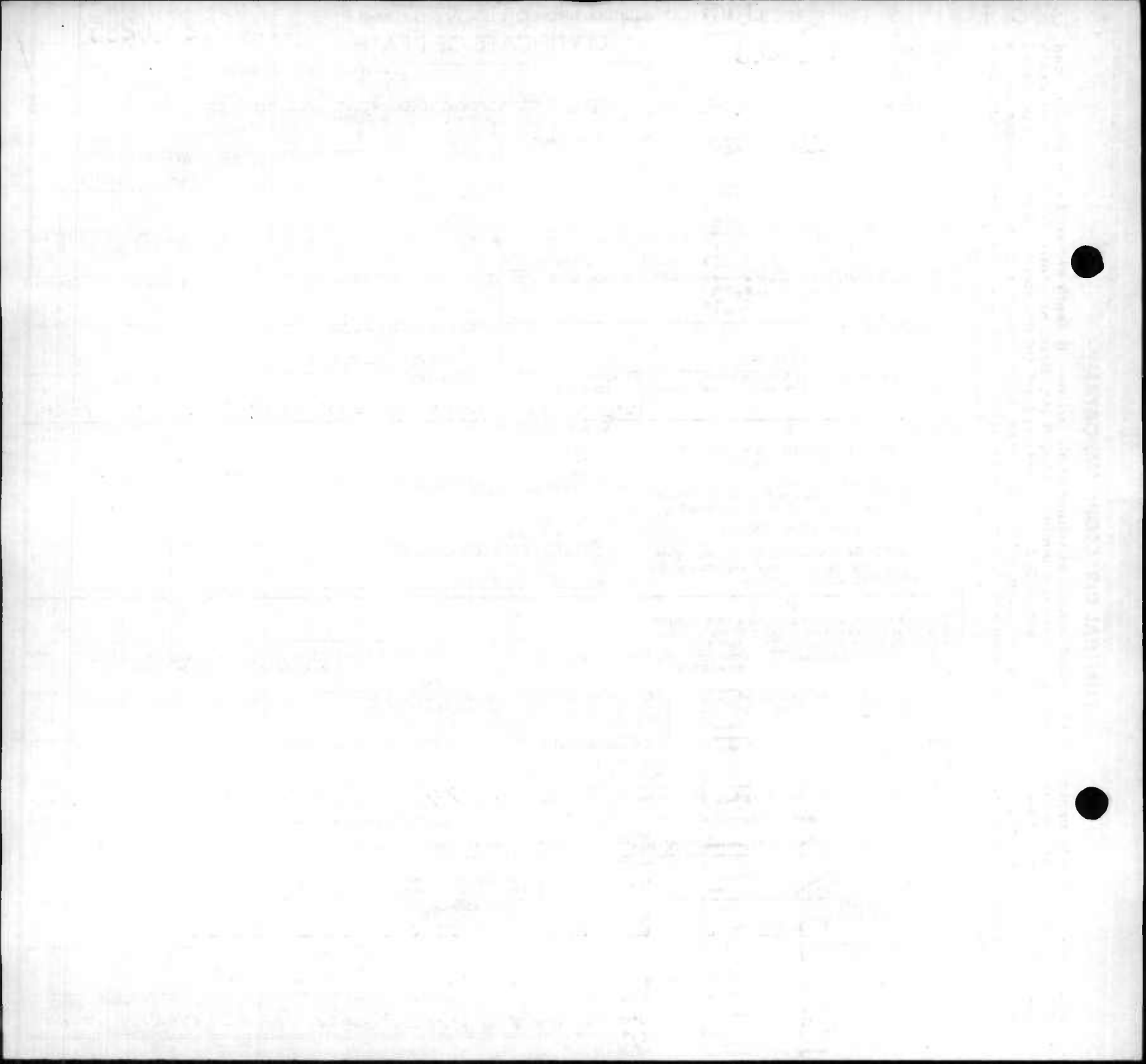
ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 72-06285

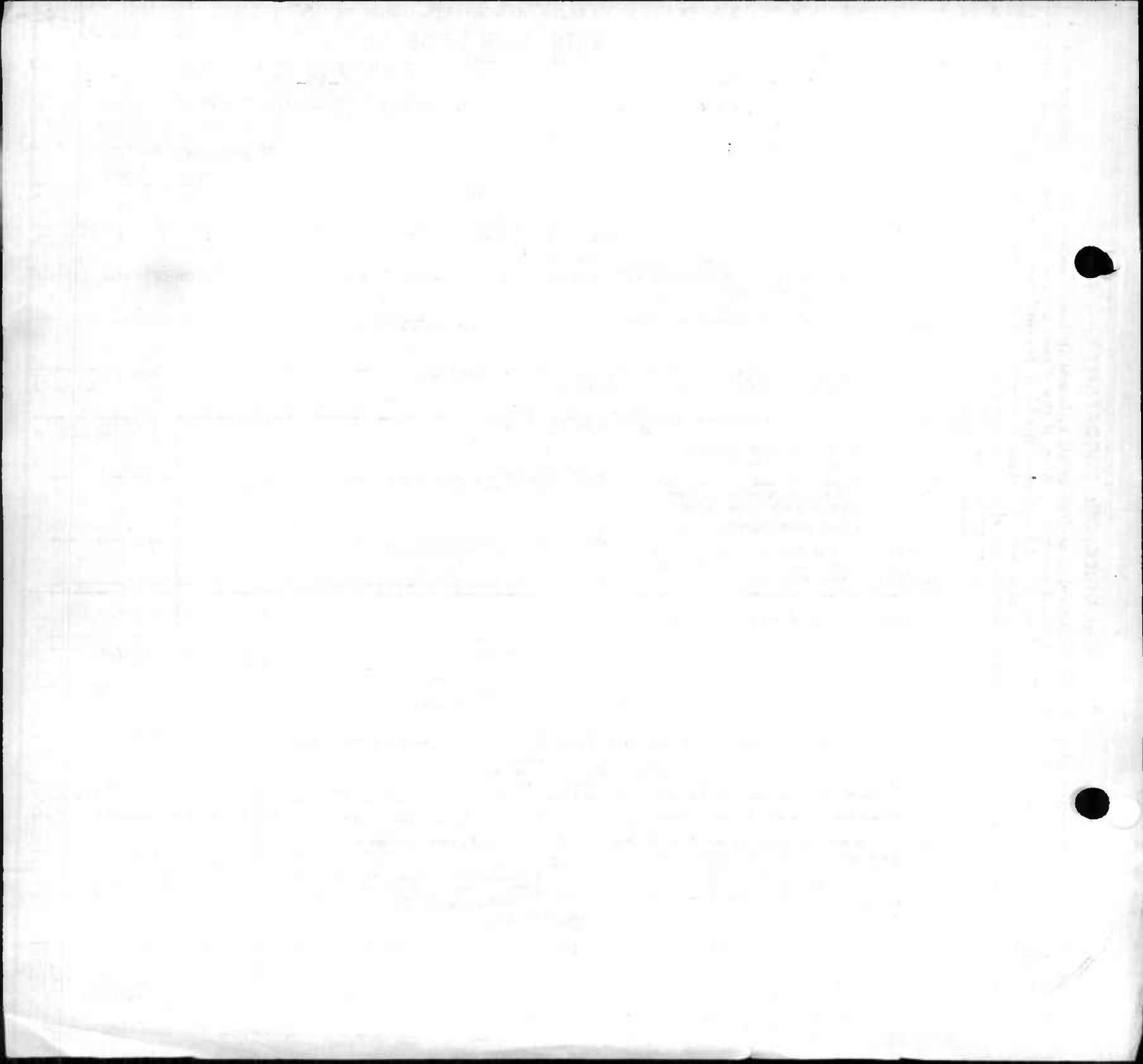
BIRTH NO. 72 06285		DATE AND HOUR OF DEATH July 4 1972 8:05 M.	
1. NAME OF DECEASED (Type or Print) Low, Walter		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital 33		A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1907 Sherwood Ave.	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/25/14
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		9. AGE (in years last birthday) 58	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME SIDNEY HICKS	
14. MOTHER'S MAIDEN NAME SARAH LAWS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 216-12-3188		17. INFORMANT ANNA M. LOW 1907 SHERWOOD AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: S/P M I 26 days Discovered 1966 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Diabetes Mellitus (C) Azotemia II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/24/72 to 7/4/72 that (2) (we) lost saw the deceased alive on 7/4/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Harry R. Jacobson M.D.		23B. DATE SIGNED 7-4-72	
23C. PHYSICIAN'S NAME (Type) HARRY R. JACOBSON M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-8-72	
24C. NAME of CEMETERY or CREMATORY BALTIMORE CEM.		24D. LOCATION (City, town, or county) (State) BALTO., MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR WM C MARCH		25D. ADDRESS 928 E. NORTH AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

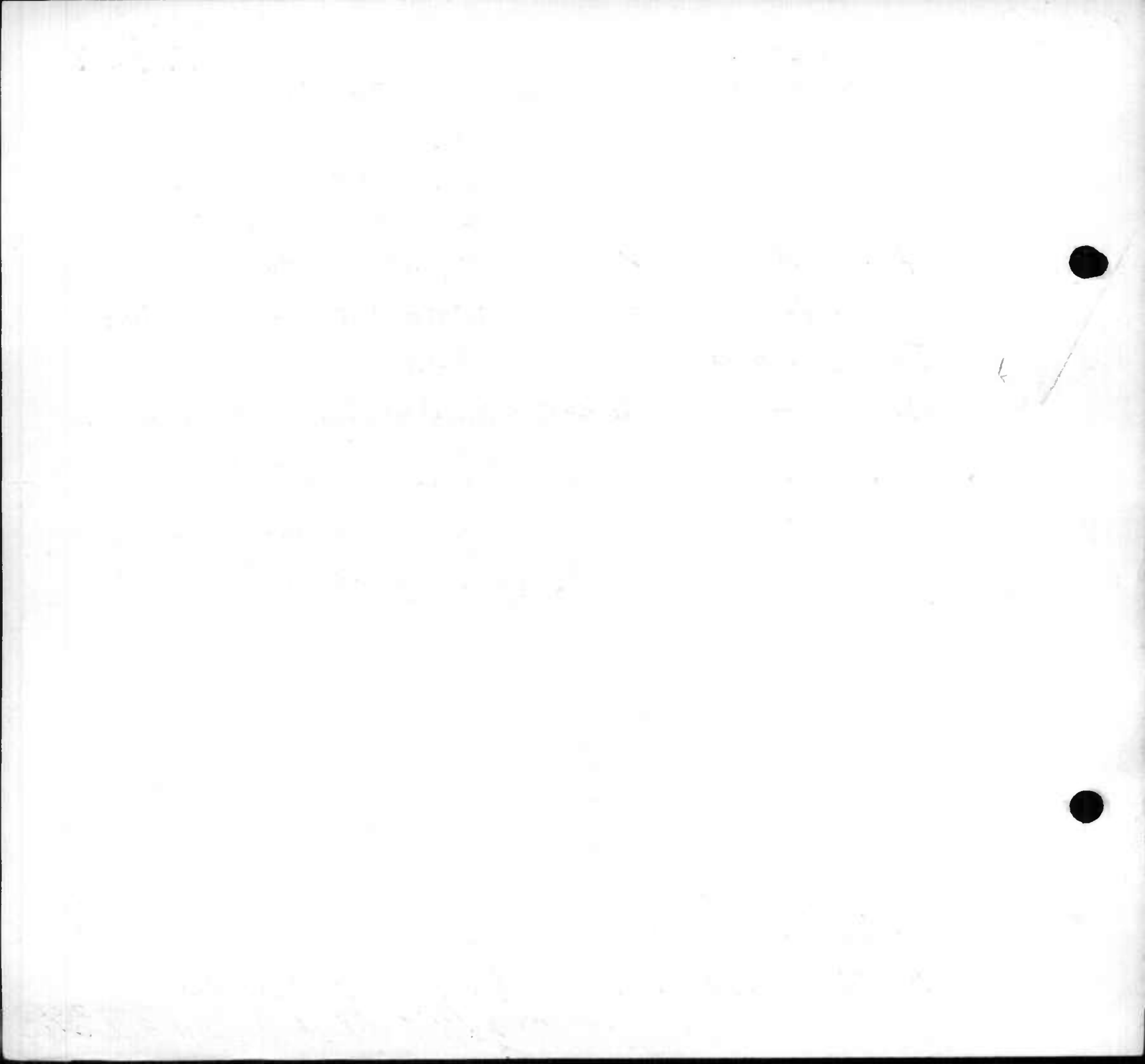
STATE OF MARYLAND-DHMH				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06286	
BIRTH NO. 72 6286				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Leroy Kirkland				2. DATE AND HOUR OF DEATH 6-30-72		10:00a M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital 37				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Balto City C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 607 W. Hoffman St. 21201			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-10-00	9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coast Guard	11. BIRTHPLACE (State or foreign country) Alabama	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Williams			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?				16. SOCIAL SECURITY NO. 216-14-4753		17. INFORMANT Patient Gloria Knight E. LaFayette	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 216-14-4753-T CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from May 19 72 to June 30 19 72 that (I) (we) last saw the deceased alive on June 30 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE 6A Mitchell MD 23B. DATE SIGNED 6/30/72 23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS Mercy Hospital, Balto. Md. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 7-3-72 24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery 24D. LOCATION Cedar Hill Md 25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972 25B. NAME OF REGISTRAR Audrey Horton 25C. FUNERAL DIRECTOR Charles Evans Hughes ADDRESS 1532 Hollins St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DEMH BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH										REG. NO. 446	
BIRTH NO. 72 06287		2. DATE AND HOUR OF DEATH 7-5-72 @ 10:35 AM									
1. NAME OF DECEASED (Type or Print) KURTH, GLADYS, L											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Harbor View Nursing Center						A. STATE MD. 1803					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						C. CITY OR TOWN BALTIMORE					
						D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
						E. STREET AND NUMBER 1240 W. Lombard St.					
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/1/13		9. AGE (In years last birthday) 59		10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wood						14. MOTHER'S MAIDEN NAME Rath					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-24-7118		17. INFORMANT Mrs. D. Schilling Baltimore, MD					
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Aneurysm					
ANTECEDENT CAUSES						(B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Aneurysm					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(C) Peptic ulcer					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Gladys V. Patricia						23B. DATE SIGNED 7/5/72				23C. PHYSICIAN'S NAME (Type) Gladys V. Patricia	
23D. ADDRESS Harbor View Nursing						23E. DATE SIGNED 7/5/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/8/72				24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			
24D. LOCATION Ball C. Md.				24E. DATE SIGNED 7/8/72				24F. NAME OF REGISTRAR Audrey H. Hoston			
24G. DATE REC'D BY HEALTH DEPT. JUL 6 1972				24H. NAME OF REGISTRAR Audrey H. Hoston				24I. FUNERAL DIRECTOR St. Schuch Inc. 2101 Frederick Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6-240-72 06288		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06288	
BIRTH NO. STATE OF MARYLAND-DEMT		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GASKILL, - BABY BOY		2. DATE AND HOUR OF DEATH 7-1-72 11:15 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Baltimore, Md. 21224		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE MARYLAND B. COUNTY Willards 21874 C. CITY OR TOWN WILLARDS D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7200			
5. SEX MALE	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-72	9. AGE (In years last birthday) 5	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALLEN, T. GASKILL		14. MOTHER'S MAIDEN NAME BETTY JEAN WHITE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: PREMATURITY = HYALINE MEMBRANE DUE TO, OR AS A CONSEQUENCE OF: DISEASE.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6-27-1972 to 7-1-1972 that (I) (we) last saw the deceased alive on 7-1-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kulasinshe		23B. DATE SIGNED 7-1-72			
23C. PHYSICIAN'S NAME (Type) Dr. H. P. KULASINSHE M.D.		23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. BALTIMORE CITY HOSPITALS 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-1972		24C. NAME OF CEMETERY OR CREMATORY Springhill Cemetery	
24D. LOCATION (City, town, or county) (State) Girdletree, Worcester, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972			
25B. NAME OF REGISTRAR Audrey Whorton		25C. FUNERAL DIRECTOR ADDRESS Hill-Baker-Bounds Funeral Home, Salisbury, Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

EGH 1		P-422 72 06289		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06289	
CERTIFICATE OF DEATH							
BIRTH NO. <u>STATE OF MARYLAND-DEME</u>				1. NAME OF DECEASED (Type or Print) PALUSZEWSKI, WALTER			
2. DATE AND HOUR OF DEATH JULY 1, 1972 1:35 A. M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 21228			
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER MAIDEN CHOICE LANE (ST. MARTINS)							
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-15-85	9. AGE (In years last birthday) 86	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDNER	
11. BIRTHPLACE (State or foreign country) POLAND				12. CITIZEN OF WHAT COUNTRY? Unknown			
13. FATHER'S NAME JOHN PALUSZEWSKI				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212078444		17. INFORMANT BALTIMORE, MD. 21229 ADDRESS ST. AGNES' RECORDS-CATON & WILKENS AVE.	
18. 189.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH TERMINAL CARCINOMA (METASTATIC) (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERNEPHROMA, LEFT KIDNEY (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <input type="checkbox"/> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that XX (this hospital) attended the deceased from JUNE 20, 1972 to JULY 1, 1972 , that XX (we) lost saw the deceased alive on JULY 1, 1972 and that XX (our) opinion death occurred on the date and hour and from the causes stated above XXX (we) (did) (XXX) view the body after death.							
23A. SIGNATURE Donato A. Vargas Jr.				M.D. DEGREE <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-1-72	
23C. PHYSICIAN'S NAME (Type) DONATO A. VARGAS JR. M.D.				23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-1972		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

STATE OF OHIO

WILLIAM J. WATSON

JULY 1, 1902

1:00 A.

WILLIAM J. WATSON

WILLIAM J. WATSON

WILLIAM J. WATSON

10-12-92

WILLIAM J. WATSON

WILLIAM J. WATSON

WILLIAM J. WATSON

WILLIAM J. WATSON

WILLIAM J. WATSON

JUNE 30, 1902

JULY 1, 1902

WILLIAM J. WATSON

WILLIAM J. WATSON

WILLIAM J. WATSON

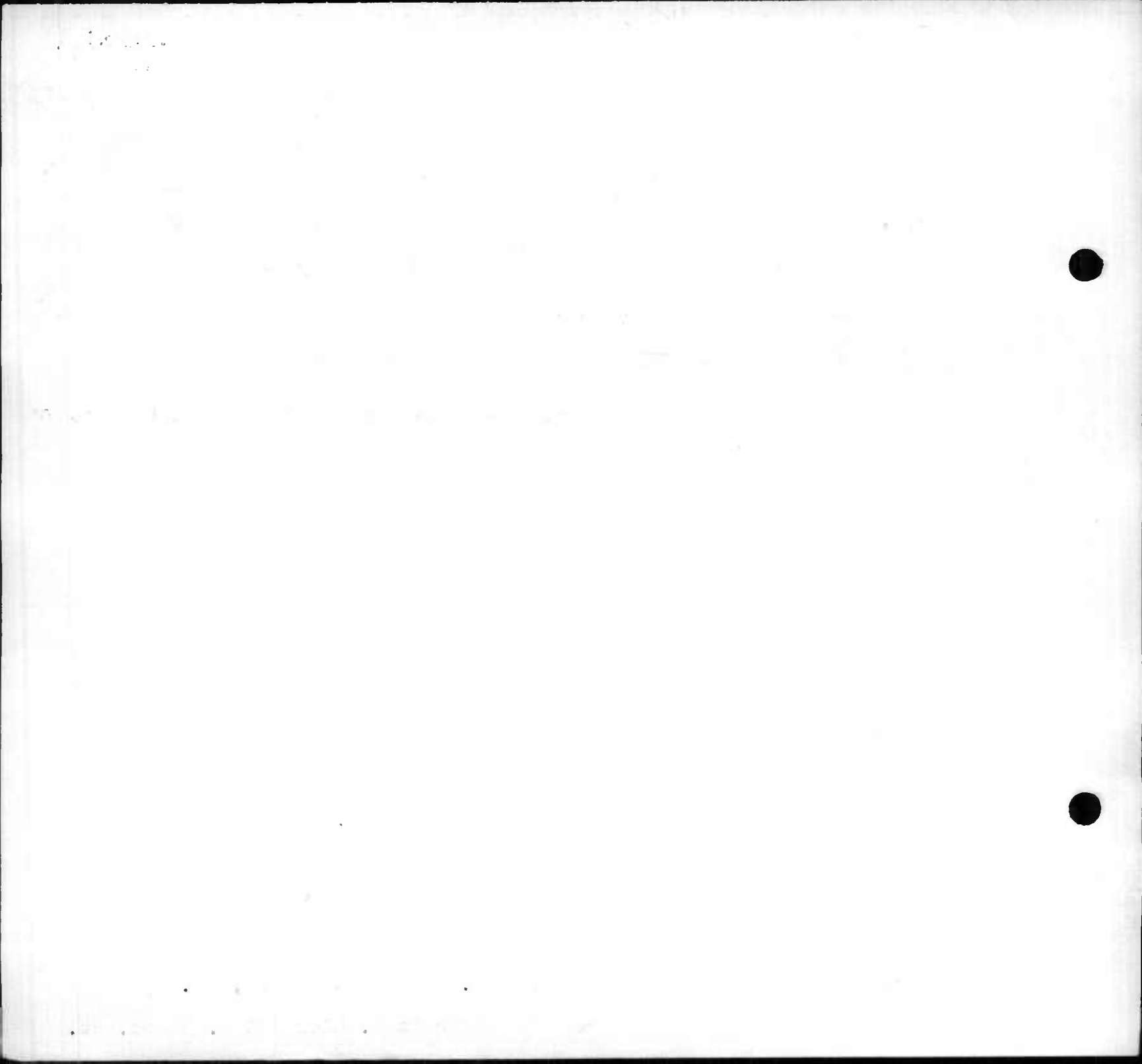
WILLIAM J. WATSON

WILLIAM J. WATSON

WILLIAM J. WATSON

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-536 12 06290		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Eugene Hunter</i>		2. DATE AND HOUR OF DEATH <i>July 2, 1972 8:00 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>34 Box Secours Hosp.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1901</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>12 N. Strickens St.</i>	
5. SEX <i>Male</i>	6. RACE <i>Black</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/15/37</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Lumber Yard</i>	9. AGE (in years last birthday) <i>34</i>
11. BIRTHPLACE (State or foreign country) <i>So Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>Jordan Hunter</i>		14. MOTHER'S MAIDEN NAME <i>Mary House</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>248-646759</i>	
17. INFORMANT <i>Annie Mae Garvins</i>		ADDRESS <i>840 Whittington Rd</i>	
18. <i>3-8-20X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Chronic renal insufficiency.</i> (A) IMMEDIATE CAUSE <i>Pericarditis. Uremia.</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>high urea in blood. friction rub.</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>A. Bhargava</i>		23B. DATE SIGNED <i>7.2.72</i>	
23C. PHYSICIAN'S NAME (Type) <i>USHA A. Bhargava</i>		23D. ADDRESS <i>Box Secours Hospital Baltimore 21223</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/7/72</i>	
24C. NAME of CEMETERY or CREMATORY <i>Mount Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1972</i>		25B. NAME OF REGISTRAR <i>Richard W. Hinton</i>	
25C. FUNERAL DIRECTOR <i>Charles A. Rice</i>		ADDRESS <i>661 W. Barre. St.</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. STATE OF MARYLAND-DEATH

REG. NO. _____

1. NAME OF DECEASED (Type or Print) LOUIS BROWN Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTO. GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour June 30, 1972 6:53 P.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12/29/58		10. AGE (In years lost birthday) 13	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY School	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Patrica Green		18. INFORMANT Patric Green	
14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2562		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY School	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Patrica Green		18. INFORMANT Patric Green	
14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2562		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	

19. E814.17 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH Multiple Injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
	(B) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			

20A. DATE OF OPERATION 6-30-72	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2800 Blk. Spellman Rd. 70 ft. S. of Windwood Ct
22D. TIME OF INJURY (APPROX.) 6-30-72 6:45 P. m.	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Collided with car while riding skate

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED 7/1/72
ACTUAL SIGNATURE Peter Lipkovic, M.D.		
EXAMINER'S NAME (Type)		

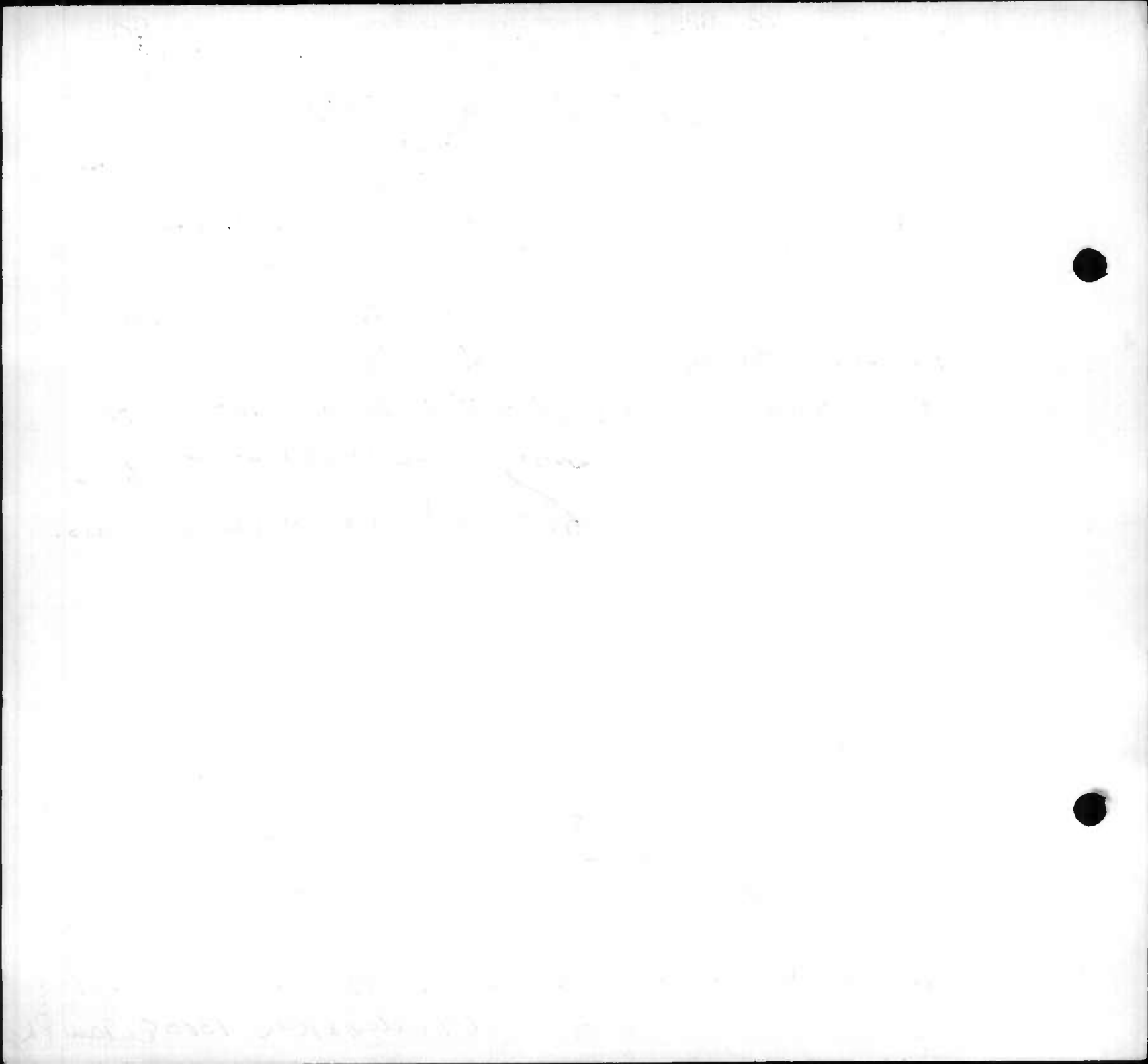
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/5/72	24C. NAME of CEMETERY or CREMATORY Church Cem.	24D. LOCATION (City, town, or county) (State) Magothy Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972	25B. NAME OF REGISTRAR Sidney Whitson	25C. FUNERAL DIRECTOR Charles A. Rice	ADDRESS 661 W. Barre St.

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-600 72 06292		BALTIMORE CITY HEALTH DEPARTMENT		72 06292	
BIRTH NO. STATE OF MARYLAND-DEME		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Johnny F. Berry</u>		2. DATE AND HOUR OF DEATH <u>5 July 72</u> <u>5:00</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1402</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland</u> <u>38 Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1521 Madison Ave</u>					
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-4-26</u>	9. AGE (In years last birthday) <u>45</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Daniel Berry</u>		14. MOTHER'S MAIDEN NAME <u>Lucille</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>216-16-6902</u>		17. INFORMANT <u>Lillie Smith - 1617 Eutaw Ph</u>	
18. <u>43091</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SUB ARACHNOID HEMORRHAGE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <u>Ruptured Intracranial Aneurysm</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>2 mos.</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-5</u> 19 <u>72</u> to <u>7-5</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7-5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>JH Ziegler MD</u>		23B. DATE SIGNED <u>7/5/72</u>		23C. PHYSICIAN'S NAME (Type) <u>JH Ziegler M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-8-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem PK</u>	
24D. LOCATION <u>Arbutus</u>		24E. CITY, TOWN, or county <u>md</u>		24F. STATE <u>md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Wharton</u>		25C. FUNERAL DIRECTOR <u>Charles & Rice</u>	
25D. ADDRESS <u>1300 Eutaw Ph</u>					



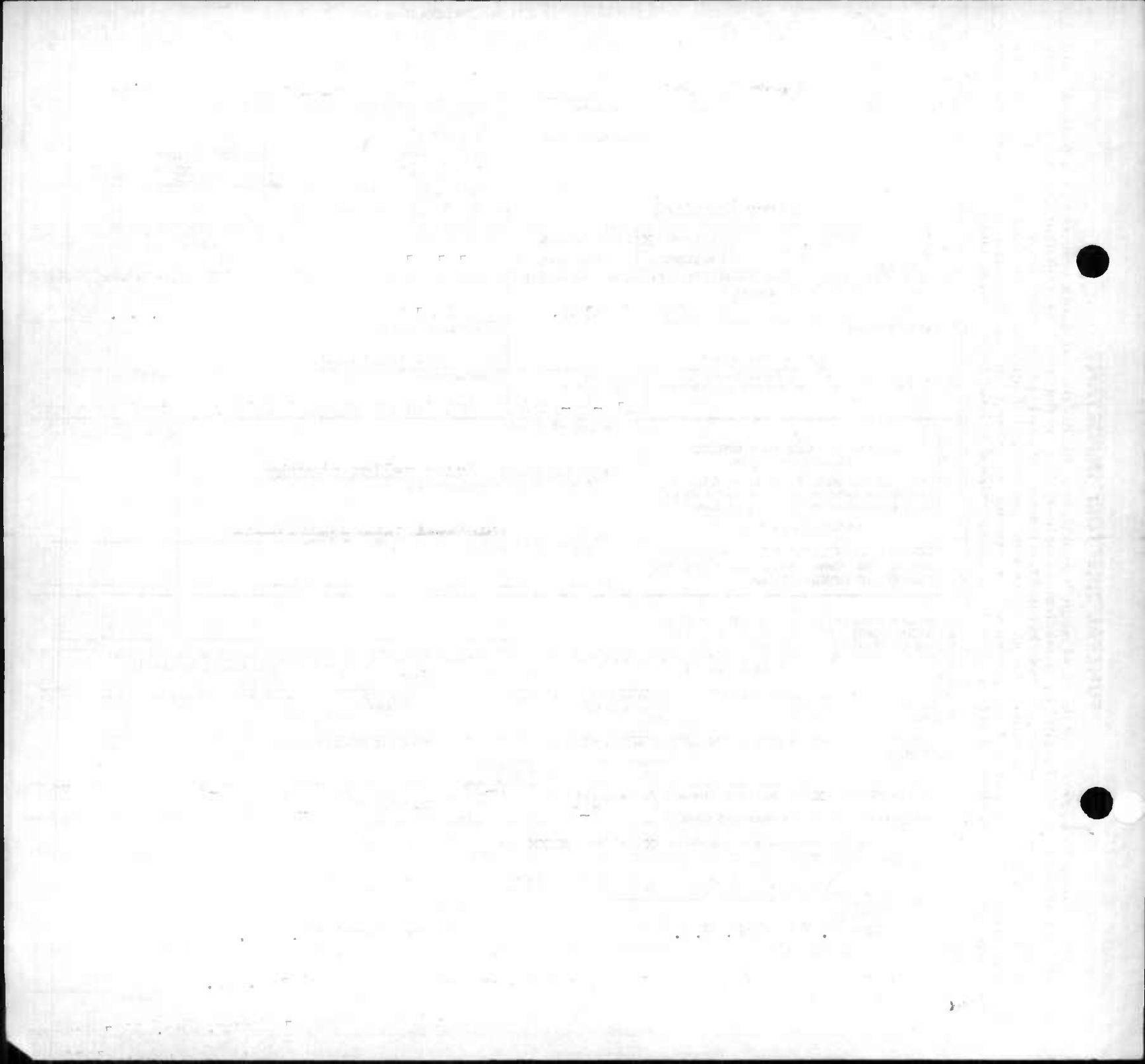
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06293			
H-655 72 06293 MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
BIRTH NO. STATE OF MARYLAND-DEMH							
1. NAME OF DECEASED (Type or Print) GEORGE HARMON				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 29, 1972			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1972 5:20 P. M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 8-14-09				10. AGE (in years lost birthday) 62		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF USA				13. FATHER'S NAME William Harmon		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1801	
15. MOTHER'S MAIDEN NAME Annita Watts				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			
17. SOCIAL SECURITY NO. 213-05-0879				18. INFORMANT ADDRESS Florence Harmon 859 Vine St.			
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. DATE OF OPERATION 0				21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) - (Day) (Year) (Hour) (Approx.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 30, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1972				25B. NAME OF REGISTRAR Lidney Weston		25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St.	

YALDEX-PCN05411

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 06294</u>
BIRTH NO. STATE OF MARYLAND-DEM 1. NAME OF DECEASED (Type or Print) <u>Mario Santoni</u>		2. DATE AND HOUR OF DEATH <u>7-3-72</u> <u>2:10 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2643</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3401 Clifftmont Ave</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/18/16</u>	9. AGE (In years last birthday) <u>56</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>City of Balto.</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Primo Santoni</u>		
14. MOTHER'S MAIDEN NAME <u>Anna Moriconi</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>213-36-5254</u>		17. INFORMANT <u>Antoinette Santoni (wife)</u> ADDRESS <u>same as above</u>		
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>570X I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) <u>IMMEDIATE CAUSE Acute yellow atrophy</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Bilateral lobe atelectasis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>7</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from <u>6-22</u> 19 <u>72</u> to <u>7-3</u> 19 <u>72</u> that (X) (we) last saw the deceased alive on <u>7-3</u> 19 <u>72</u> and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Ken R. Warrick M.D.</u>				23B. DATE SIGNED <u>7/4/72</u>
23C. PHYSICIAN'S NAME (Type) <u>Ken R. Warrick, M.D.</u>				23D. ADDRESS <u>Mercy Hospital, Inc.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/8/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1972</u>		
25B. NAME OF REGISTRAR <u>70ndy in h...</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u> ADDRESS <u>3337 Brehme Lane, Balto. Md. 21212</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-165 72 06295		BALTIMORE CITY HEALTH DEPARTMENT		72 06295	
BIRTH NO. <u>72 06295</u>		CERTIFICATE OF DEATH		REG. NO. <u>72 06295</u>	
1. NAME OF DECEASED (Type or Print) <u>LeBrun, Henrietta</u>		2. DATE AND HOUR OF DEATH <u>7-5-72</u> <u>4 05</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles General Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u>		C. CITY OR TOWN <u>Baltimore</u>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>Harbor View Nursing Home</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-6-91</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Helwig & Leitch</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Manning</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wagner</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-01-4014</u>		17. INFORMANT <u>May Lubaszewski (dghtr)</u> ADDRESS <u>1205 Willow Rd.</u>	
18. <u>599.01 + 250.9</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Septicemia.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Cellulitis Shimp @ thigh</u>		<u>2 weeks</u>	
		(C) <u>urinary tract infection.</u>			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>diabetic + A.S.H.D.</u>		<u>Stroke 2 yrs.</u>	
19A. DATE OF OPERATION <u>0 X</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>X</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-23-72</u> 19 <u>72</u> to <u>7-5-72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7-5-72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. K. MILAK</u>		23B. DATE SIGNED <u>7-5-72</u>		23C. PHYSICIAN'S NAME (Type) <u>S. K. MILAK</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/7/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. D/ REC'D BY HEALTH DEPT. <u>JUL 7 1972</u>		25B. NAME OF REGISTRAR <u>John J. Conroy</u>	
25C. FUNERAL DIRECTOR <u>Schumanek Funeral Homes, Inc.</u>		25D. ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>			

1205 W. 110W Rd 21222

12/14/91 ADM.

72 06296 BALTIMORE CITY HEALTH DEPARTMENT 72 06296
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. _____

BIRTH NO. STATE OF MARYLAND DEPT. OF HEALTH

1. NAME OF DECEASED (Type or Print) <u>(Fleury) FLEURY / SHIFFLETT</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <u>7-5-72</u>		Hour <u>1:30 P.M.</u>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Bolton Hill Nurshing Home</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year <u>July 5, 1972</u>		Hour <u>1:30 P.M.</u>
6. SEX <u>Female</u>		7. RACE <u>White</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <u>5/10/96</u>		10. AGE (In years lost birthday) <u>76</u>	11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>-</u>		13. FATHER'S NAME <u>Hyden Shifflett</u>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker at home</u>
15. MOTHER'S MAIDEN NAME <u>Manda Morris</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		17. SOCIAL SECURITY NO. <u>214-56-2707</u>
18. INFORMANT <u>James Shifflett (son)</u>		19. ADDRESS <u>same as above</u>		20. CAUSE OF DEATH <u>Arteriosclerotic cardiovascular disease</u>

19. <u>412.4</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------

20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>Yes</u>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. EXAMINER'S NAME (Type) <u>Charles S. Springate, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>July 6, 1972</u>				

24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/8/72</u>	24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Pk. Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1972</u>		25B. NAME OF REGISTRAR <u>Edmund J. Heston</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</u>

1000

1000

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VALLEY FORD

VALLEY FORD

20/10/1955

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> M-625 72 06297 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 72 06297
BIRTH NO. STATE OF MARYLAND-DHMH		
1. NAME OF DECEASED (Type or Print) MERISON, ROBERT W.		2. DATE AND HOUR OF DEATH <div style="display: flex; align-items: center;"> 07-06-72 3:57 A. </div>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION Church Home and Hospital 100 N. Broadway St Baltimore MD 21231 </div> <div style="flex: 1;"> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2634
5. SEX M		6. RACE W
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 07-28-06
9. AGE 65 years (last birthday)		10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY self-employed
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME ROBERT W. Merison		14. MOTHER'S MAIDEN NAME Lucy McGuire
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 017-10-0961
17. INFORMANT A-Samad Nour		ADDRESS Church Home Hosp.
18. CAUSE OF DEATH <div style="display: flex;"> <div style="flex: 1;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="flex: 1;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Renal Failure ASCVD - C.H.F. </div> <div style="flex: 1;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH many years many years </div> </div>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none
20A. AUTOPSY? (Yes or No) none		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none		
21D. TIME OF INJURY (Approx.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR? none		
22. I certify that (I) (this hospital) attended the deceased from 5-10-1972 to 7-6-1972 that (I) (we) last saw the deceased alive on 7-6-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE A-Samad Nour		23B. DATE SIGNED 7-6-72
23C. PHYSICIAN'S NAME (Type) A-SAMAD NOUR		23D. ADDRESS Church Home Hospital
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/10/72
24C. NAME OF CEMETERY or CREMATORY Crest Lawn Cemetery		24D. LOCATION (City, town) or county (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Sidney H. Hooton
25C. FUNERAL DIRECTOR Schimmek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213

W. T. S. & Co. Inc.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06298	
<div style="display: flex; justify-content: space-between;"> R-200 72 06298 </div>					
BIRTH DATE OF JAN 29 1906 1. NAME OF DECEASED BENJAMIN F. ROSS (Type or Print)			2. DATE AND HOUR OF DEATH 29 June 72 1:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 44			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Sykesville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Klees Mill Road R.D. 6		
5. SEX M.	6. RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/06	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months Days Hours Min. 7 2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer			11. BIRTHPLACE (State or foreign country) Dover, Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Ross			14. MOTHER'S MAIDEN NAME Sarah ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-09-3405		17. INFORMANT ADDRESS Hospital Records-Union Memorial Hospital
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center; font-weight: bold;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/23 19 72 to 6/29 19 72 that (I) (we) last saw the deceased alive on 6/29 19 72 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry J. Weckesser MD				23B. DATE SIGNED 29 June 1972	
23C. PHYSICIAN'S NAME (Type) Barry J. Weckesser MD				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial 7/3/1972		24C. NAME of CEMETERY or CREMATORY Lakeview Memorial		24D. LOCATION (City, town, or county) (State) Carroll Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Sidney [unclear]		25C. FUNERAL DIRECTOR ADDRESS C.M. Waltz, Box 326, Sykesville, Md.	

[Faint, mostly illegible text at the top of the page, possibly a header or introductory paragraph.]

[A large block of very faint, illegible text in the middle of the page, appearing to be the main body of a letter or report.]

[Faint text at the bottom of the page, which may include a signature, date, or closing remarks.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 66299</u>	
<div style="display: flex; justify-content: space-between;"> <u>1</u> <u>D-620</u> <u>72 66299</u> CERTIFICATE OF DEATH </div>					
BIRTH NO. STATE OF MARYLAND-DEPT 1. NAME OF DECEASED (Type or Print) <u>LOUIS W. DORSEY Jr</u>			2. DATE AND HOUR OF DEATH <u>07-01-72</u> <u>10:00 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>BALTIMORE, MD 21205</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>MONTGOMERY</u> C. CITY OR TOWN <u>SILVER SPRING</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>9305 MINTWOOD STREET</u>		
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11-20-06</u>		9. AGE (In years lost birthday) <u>65</u>		10. AGE (In years lost birthday) <u>65</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Food</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>LOUIS W. DORSEY</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE HENDERSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-16-4525</u>		17. INFORMANT <u>HELEN DORSEY</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.91 + 199.0 MYOCARDIAL INFARCT</u>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>MYOCARDIAL INFARCT</u>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 H</u>	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II METASTATIC CARCINOMA</u>		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>1</u>		23. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
24. DATE OF OPERATION <u>2</u>		25. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>NO</u>	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>NO</u>		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u>	
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>NO</u>		31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		32. HOW DID INJURY OCCUR? <u>NO</u>	
33. I certify that (1) (this hospital) attended the deceased from <u>July 1972</u> to <u>July 1972</u> and that (2) (we) lost saw the deceased alive on <u>July 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.					
34. SIGNATURE <u>A.S. Giritsky M.D.</u>				35. DATE SIGNED <u>July 1972</u>	
36. PHYSICIAN'S NAME (Type) <u>A.S. GIRITSKY M.D.</u>				37. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
38. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		39. DATE <u>7-5-72</u>		40. NAME OF CEMETERY OR CREMATORY <u>ST MARKS Cem.</u>	
41. LOCATION (City, town, or county) (State) <u>Highland, Md.</u>		42. NAME OF REGISTRAR <u>JUL 7 1972</u>		43. FUNERAL DIRECTOR <u>SLACK F.H. ELLIOTT & SONS, MD 21043</u>	

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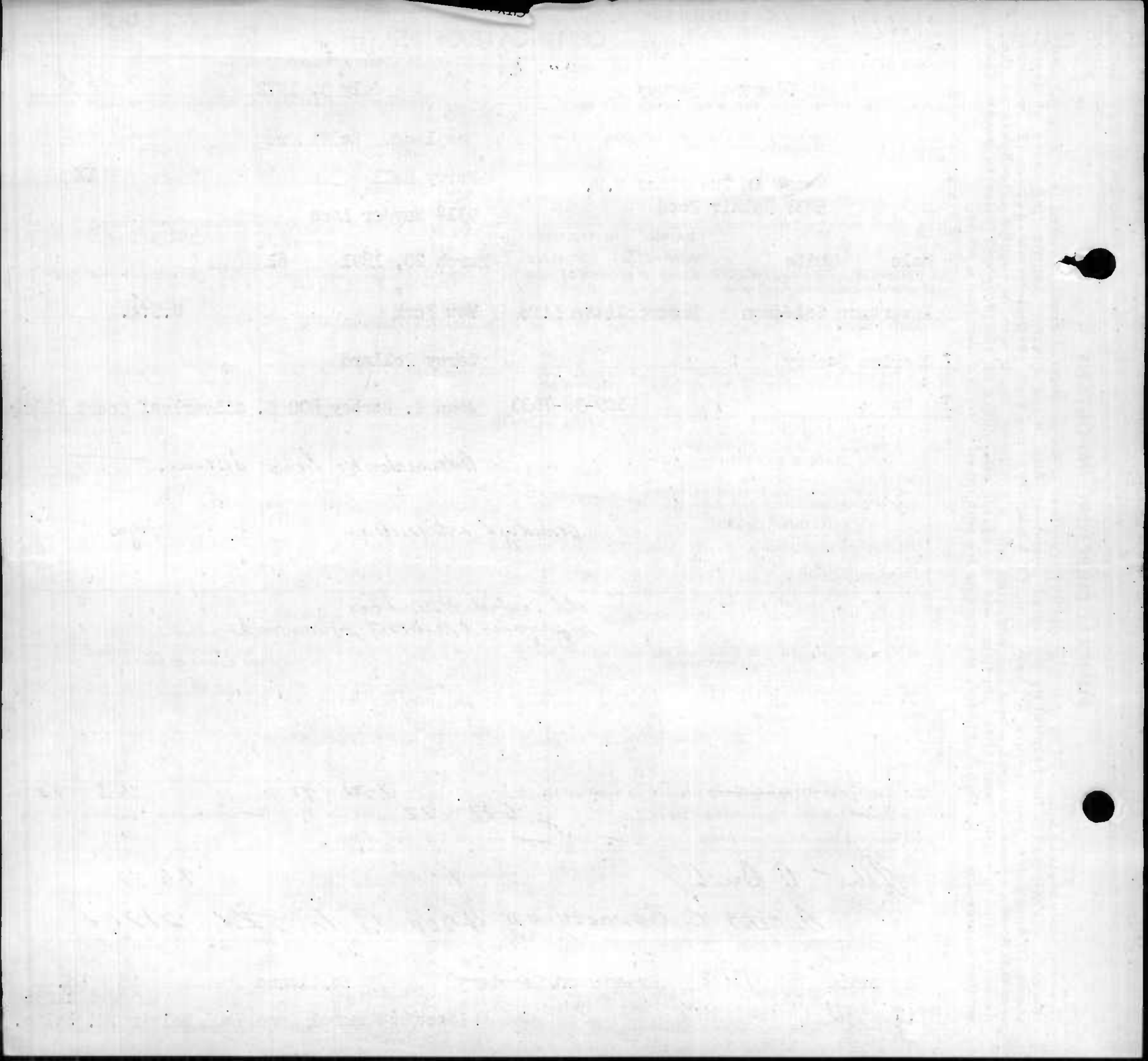
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

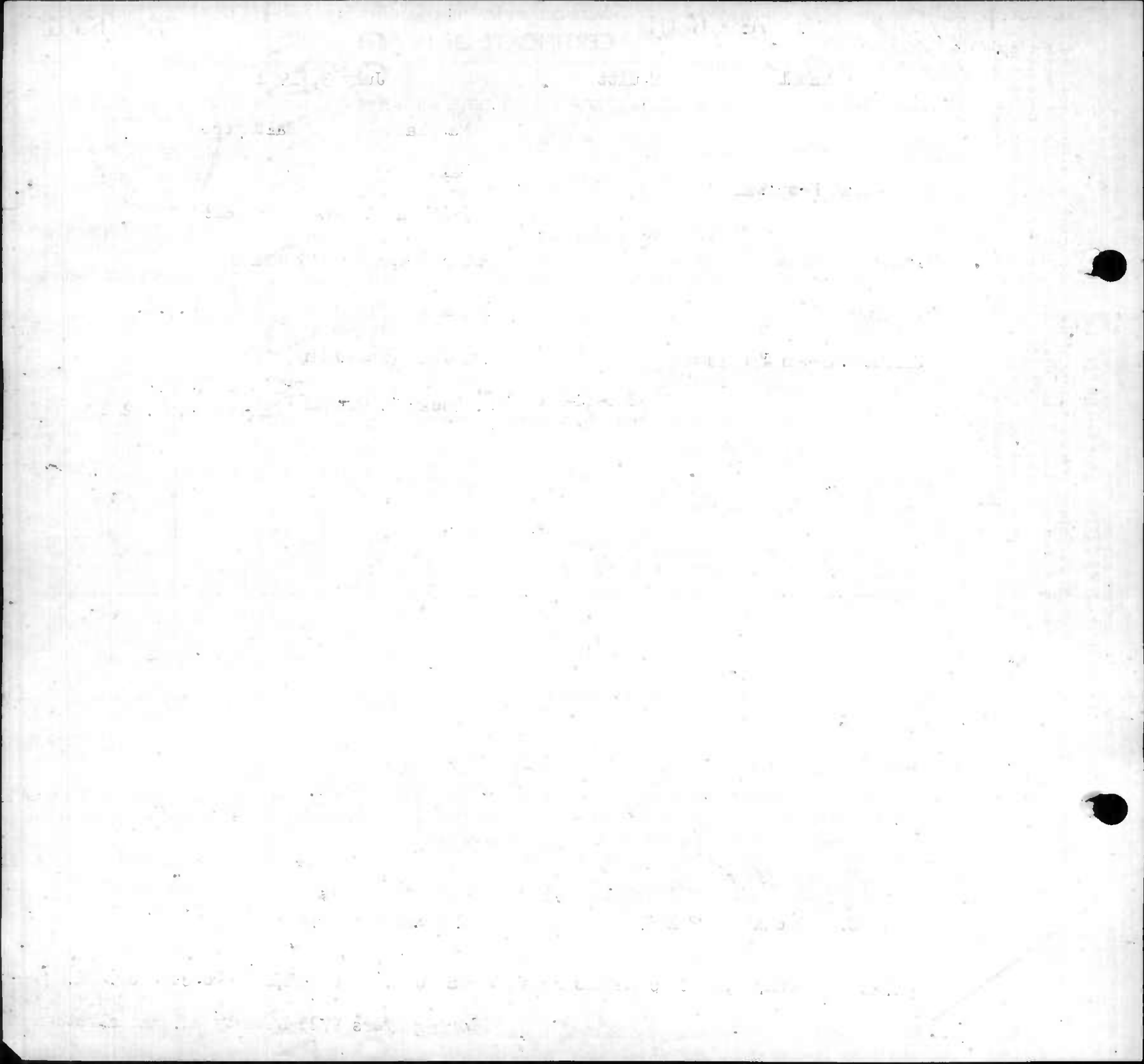
B-6LD 72 06300		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06300	
BIRTH NO. STATE OF MARYLAND-DHMH				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Frank Clarence Barbey			2. DATE AND HOUR OF DEATH July 3, 1972 4:05 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House In The Pines N.H. 5837 Belair Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Perry Hall D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 9318 Snyder Lane		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1891	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Salesman		10B. KIND OF BUSINESS OR INDUSTRY Metropolitan Life		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Charles Barbey			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 109-38-7633		17. INFORMANT John E. Barbey
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). old cerebral thrombosis emphysema & recent pneumonia			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic heart disease (B) Genetically determined DUE TO, OR AS A CONSEQUENCE OF: hypertension (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-24 19 72 to 7-3 19 72 . that (I) (we) last saw the deceased alive on 6-27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 7-5-72	
23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY, M.D.				23D. ADDRESS 4900 Belair Rd. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7/5/72		24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery	
24D. LOCATION Baltimore		24E. ADDRESS Md.		24F. ADDRESS 21236	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Frederick M. ...		25C. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Rd. Balto.	



FUNERAL DIRECTOR: IMPORTANT

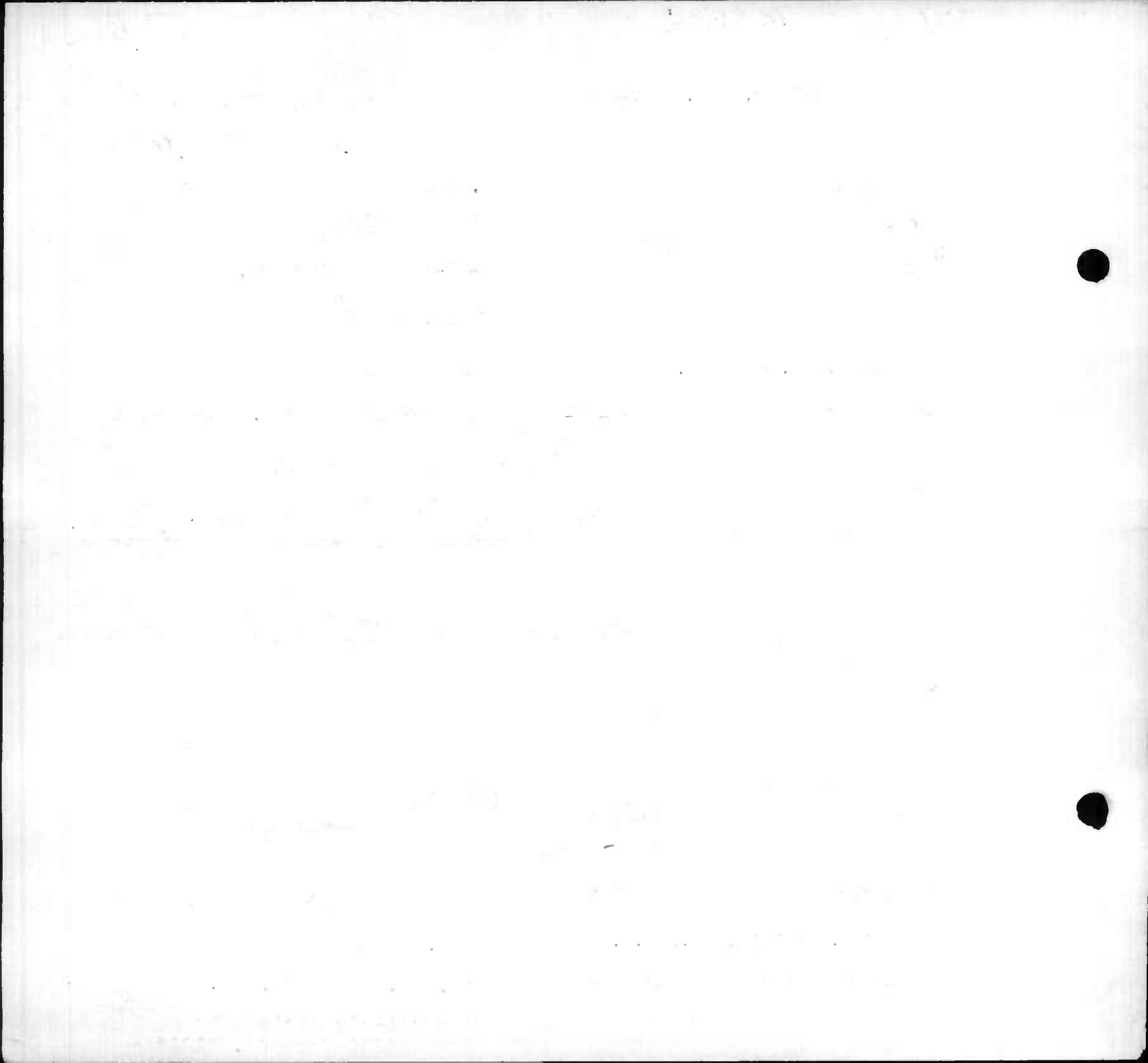
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-630		72 06301		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		72 06301	
BIRTH NO.		STATE OF MARYLAND-DEPT		1. NAME OF DECEASED (Type or Print)		Mabel Truitt		2. DATE AND HOUR OF DEATH	
						July 3, 1972		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY			
42 Sinai Hospital				Maryland		Baltimore		5300	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
				Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER					
				3819 Oak Avenue		21207			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		October 4, 1898		73 years	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Homemaker						Indiana		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
William Martin Thompson				Eva Jean (nee Denny)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO				262-22-1800		Mr. Oscar P. Truitt		3819 Oak Avenue Baltimore, Md. 21207	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				(B) Anterior causes DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) 4-8 years					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
D				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Dec 19 21 to Jan 19 72				that (I) (we) last saw the deceased alive on 6/27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
Richard Fravel				DEGREE		7/3/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
C. Richard Fravel				1201 Malvern Avenue					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		July 6, 1972		McKemmies Presbyterian Cem.		Snow Hill Worcester Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 7 1972		Loring Byers		8728 Liberty Rd. Randallstown, MD					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-631		72 06302		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06302	
BIRTH NO. STATE OF MARYLAND-DEMH				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HEARTFIELD, MRS. FRANCES				2. DATE AND HOUR OF DEATH July 1, 1972 10 30 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) KESWICK HOME				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 0000			
5. SEX F 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 3-11-1897		9. AGE (In years last birthday) 75 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PARIS, FRANCE	
13. FATHER'S NAME MULLIKEN, MR. HARRY B.				12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 220-24-2877		17. INFORMANT Keswick files 700 W. 40th street	
18. 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE AND ARTERIOSCLEROTIC HEART DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: Heart disease (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours many years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Encephalomalacia due to cerebral arteriosclerosis				19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22. I certify that (I) (this hospital) attended the deceased from 7/14/69 19 to 7/1/72 19 that (I) (we) last saw the deceased alive on 7/1/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W.B. Daniels, Jr. M.D.				23B. DATE SIGNED 7/3/72		23C. PHYSICIAN'S NAME (Type) WORTH B. DANIELS, JR., M.D.	
23D. ADDRESS 700 W. 40th STREET				23E. FUNERAL DIRECTOR Mitchell-Wiedefeld Home			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/5/72		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Gar.	
24D. LOCATION Balto. Co.				24E. ADDRESS 6500 York Rd. 21212			
25A. DATE REC'D BY HEALTH DEPT. JULY 1972				25B. NAME OF REGISTRAR James M. Smith			



P-616

72 06303

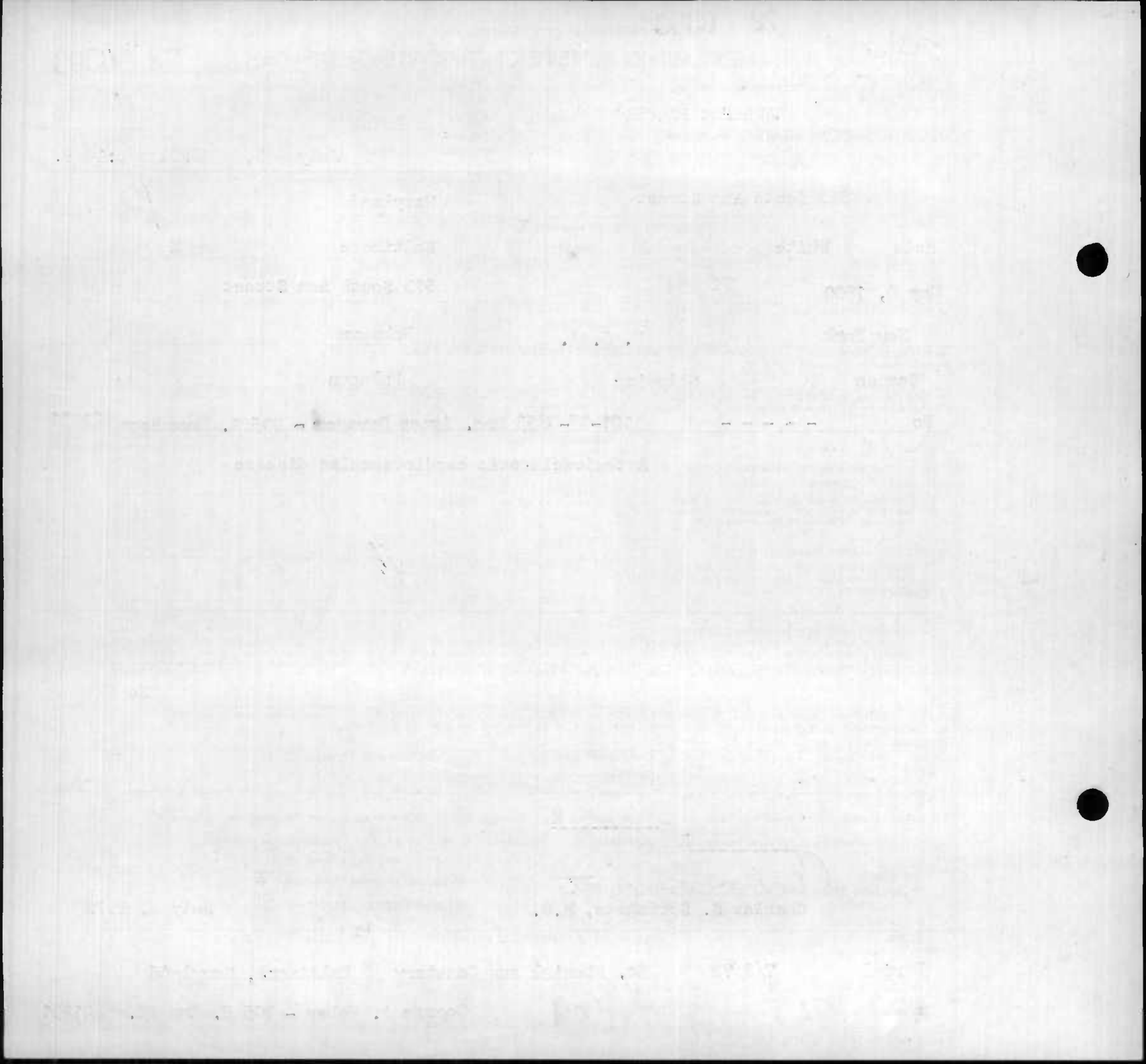
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06303

BIRTH STATE OF MARYLAND-DEATH

1. NAME OF DECEASED (Type or Print) LAWRENCE PROPER				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 523 South Ann Street				3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1972 6:10 P.			
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH May 8, 1900				10. AGE (In years last birthday) 72		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Unknown			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman				15. MOTHER'S MAIDEN NAME Unknown			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 121-05-0853		18. INFORMANT ADDRESS Mrs. Agnes Garayoa - 805 S. Broadway #21231	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 6, 1972							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Andrew Johnson		25C. FUNERAL DIRECTOR ADDRESS George A. Weber - 705 S. Ann St. #21231			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06304		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06304	
BIRTH NO. STATE OF MARYLAND-DHMH					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Louis / Violi			7-4-72 8:10 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc.			A. STATE Maryland B. COUNTY 2743 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1634 Walther Blvd		
5. SEX M	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/1885	9. AGE (In years last birthday) 86	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Copper-smith Self-employed			11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Louis L. Violi same
18. I 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary embolism (B) DUE TO, OR AS A CONSEQUENCE OF: Ca of colon & metastases - 6 months (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 4 1972 to July 4 1972 that (I) (we) last saw the deceased alive on July 4 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) J. G. LUSHAKA				23D. ADDRESS DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972			
25B. NAME OF REGISTRAR Sidney H. Hinton		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto., Md.			

11/9/1952

2

11/9/1952

11/9/1952

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11/9/1952

11/9/1952

72 06305

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06305

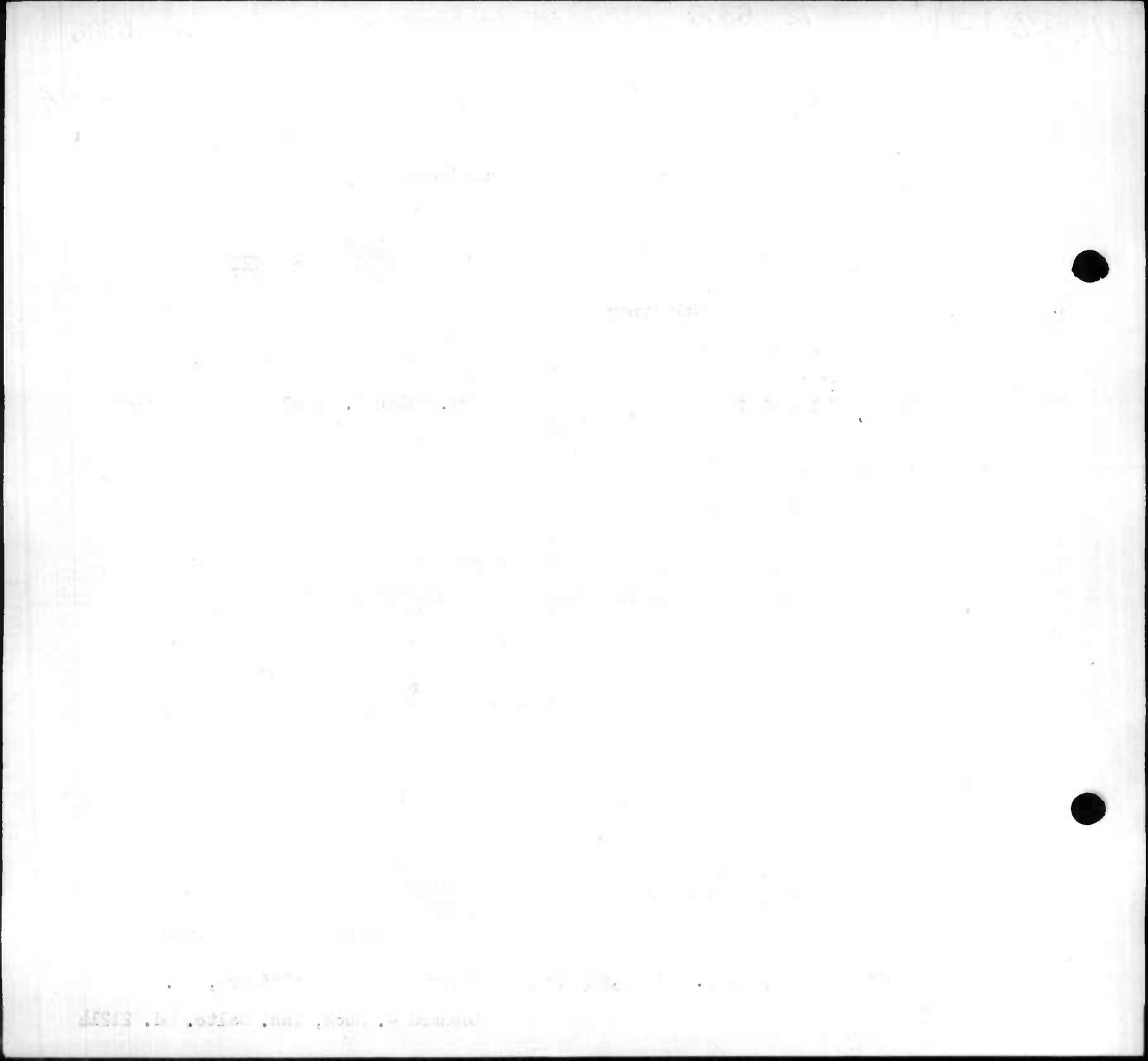
BIRTH NO. STATE OF MARYLAND - DIME

1. NAME OF DECEASED (Type or Print) KEITH SHELLMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 8-21-72		3. DATE PRONOUNCED DEAD Month Day Year Hour July 3, 1972 2:20 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1202	
9. DATE OF BIRTH 2/15/1954		10. AGE (In years lost birthday) 18 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Randolph W. Shellman Sr.		14. MOTHER'S MAIDEN NAME Elaine W. Cwerking	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT S/4 Randolph W. Shellman		ADDRESS Petersburg, Va. 423 S. Sycamore St	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E985X1 Gunshot wound of head		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes (head-only)			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? 402 Venable Avenue		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 7-3-72 1:00 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Self-inflicted	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/4/72	
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72	
24C. NAME of CEMETERY or CREMATORY Dulaney Valley		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md.	

8-21-1972 - Letter from the Office of the Chief Medical Examiner, Ronald N. Kornblum, M.D.
Deputy Chief Medical Examiner. HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72-06306		BALTIMORE CITY HEALTH DEPARTMENT		72-06306	
BIRTH STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) VOGEL, Mr FRANCIS J.		2. DATE AND HOUR OF DEATH 7/6/72 10:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital. 35		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN Baltimore City D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2401 HAMILTON AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1900 12/12/102	9. AGE (In years last birthday) 71	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.		10B. KIND OF BUSINESS OR INDUSTRY Cab Owner		11. BIRTHPLACE (State or foreign country) MARYLAND.	
13. FATHER'S NAME JOSEPH VOGEL		14. MOTHER'S MAIDEN NAME JORA SOUL.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW1 & WW 2		16. SOCIAL SECURITY NO. 217-03-6820		17. INFORMANT Mrs. Helen G. Vogel ADDRESS (Same)	
18. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH ASPIRATION PNEUMONIA. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC OBSTRUCTIVE PULMONARY DISEASE. ANEMIA - (B) DUE TO, OR AS A CONSEQUENCE OF: URINARY TRACT INFECTION - (C) CONGESTIVE HEART FAILURE. ARTERIOSCLEROSIS. CAR. VASC. DISEASE. ATRIAL FIBRILATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediately. years. N ✓	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/4/72 19 to 7/6/72 19 that (I) (we) last saw the deceased alive on 7/6/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walker H. Impagliatelli		23B. DATE SIGNED 7/6/72		23C. PHYSICIAN'S NAME (Type) WALKER H. IMPAGLIATELLI	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/72.		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972			
25B. NAME OF REGISTRAR Richard W. Ruck		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			



BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06307

BIRTH NAME STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) TERRY ESTES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 SOUTH BALTO. GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour June 30, 1972 7:55 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2562	
9. DATE OF BIRTH 12-28-1957		10. AGE (In years last birthday) 14 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roland Estes		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student	
15. MOTHER'S MAIDEN NAME Eloise Oglesby		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. none		18. INFORMANT ADDRESS Mrs. Eloise Estes 2829 Spellman Road	
19. E 814.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Craniocerebral Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2800 Blk. Spellman Rd. 70 ft. S. of Windwood			
22D. TIME OF INJURY (APPROX.) 6-30-72 6:45 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Collided with car while riding skate			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/1/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-1972	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR <i>Sidney Wharton</i>	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVE	

VS 151-REV. 1/1/68

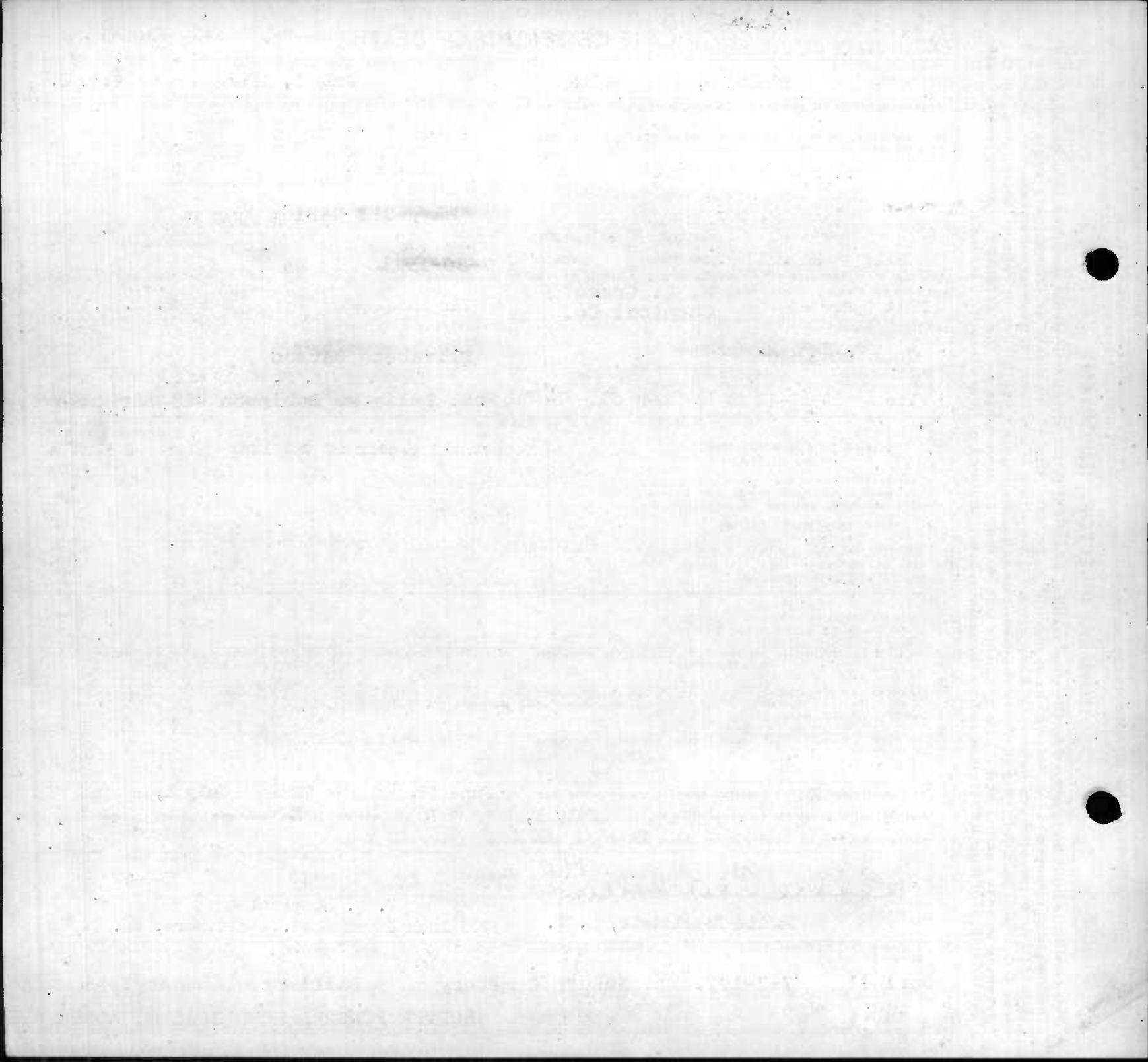
WALL-BLEY BOHNS

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

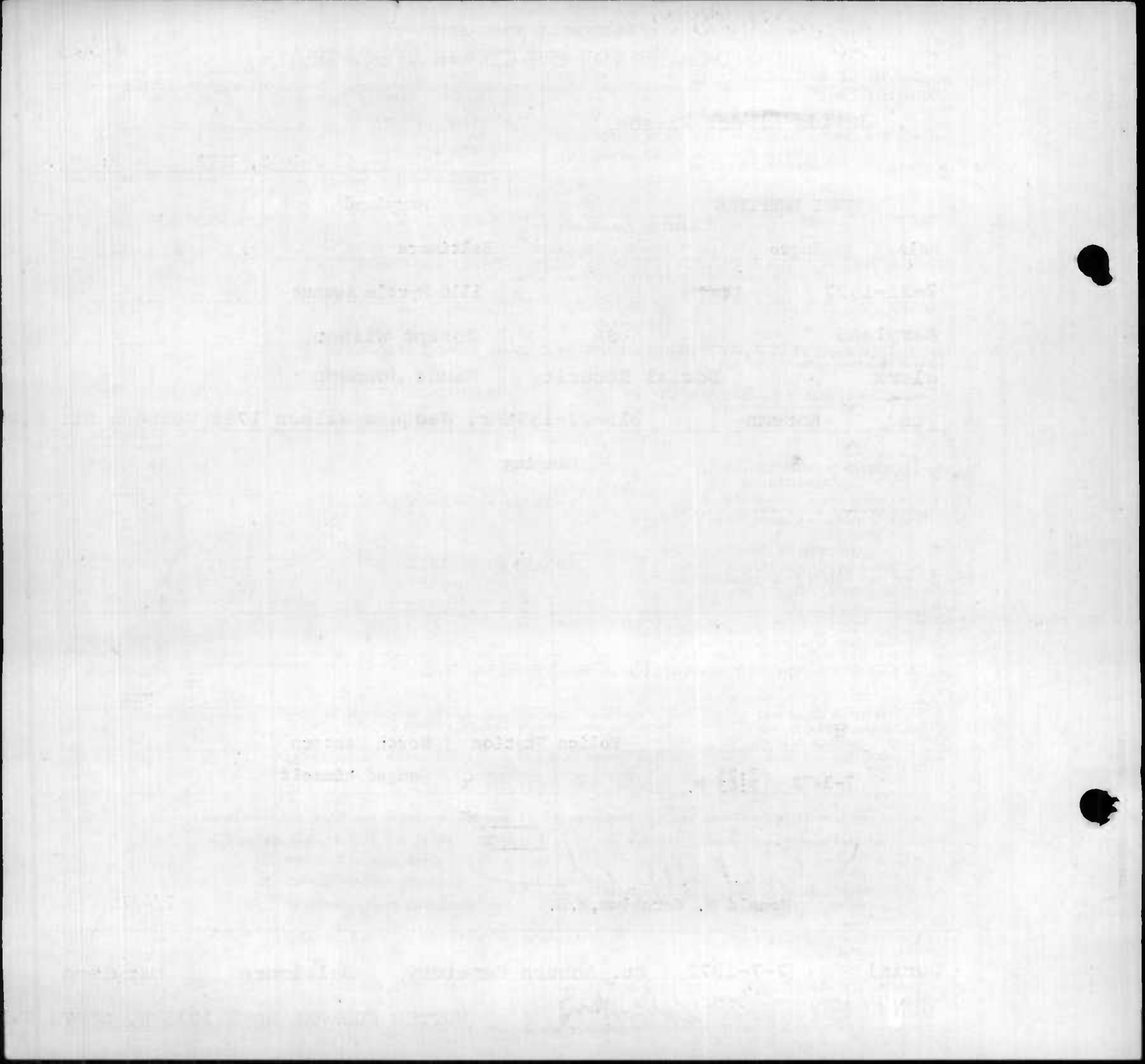
R-152 72 66308		Baltimore City Health Department		REG. NO. 72 66308	
BIRTH NO. STATE OF MARYLAND-DEMD		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
ROBINSON, JOHN JUNIOR		July 1, 1972 2:50 P. M.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland Baltimore		5. SEX Male 6. RACE Negroid		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8. DATE OF BIRTH 7-30-1911 9. AGE (In years last birthday) 60	
E. STREET AND NUMBER 813 Harlem Avenue		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unit Operator		10B. KIND OF BUSINESS OR INDUSTRY W. R. Grace Chemical Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Robinson	
14. MOTHER'S MAIDEN NAME Elizabeth Datson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11-14-42 to 11-21-42		16. SOCIAL SECURITY NO. 215-07-7818	
17. INFORMANT Mrs. Lelia B. Robinson		18. ADDRESS 813 Harlem Ave.		19. CAUSE OF DEATH Metastatic cancer of the lung	
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months		21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 27, 1972 to July 1, 1972, that (I) (we) last saw the deceased alive on July 1, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leslie Pearlstein MD		23B. DATE SIGNED 7-2-72		23C. PHYSICIAN'S NAME (Type) Leslie Pearlstein, M. D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-1972		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION Baltimore		24E. STATE Maryland		24F. ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE	
25A. DATE REC'D. BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]	



W-425 72 06309
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
72 06309
STATE OF MARYLAND-DEMH
BIRTH NO. _____ REG. NO. _____

1. NAME OF DECEASED (Type or Print) Julius Elbert Wilson		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 3, 1972 8:00 P.M.	
6. SEX Male		7. RACE Negro	
8. B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7-21-1927		10. AGE (In years lost birthday) 44	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Wilson		14. MOTHER'S MAIDEN NAME Maude Johnson	
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1703		E. STREET AND NUMBER 1110 Myrtle Avenue	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Korean		17. SOCIAL SECURITY NO. 219-22-1336	
18. INFORMANT Mr. Jacques Wilson		ADDRESS 1795 Vesbena St. N.W.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E 953X		CAUSE OF DEATH Hanging	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. DATE OF OPERATION 2		23. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Police Station	
26. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-3-72 7:25 P. m.		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) North Western	
28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		29. HOW DID INJURY OCCUR? Hanged himself	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/4/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-1972	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVENUE	

VS 151-REV. 1/1/68
N994.7



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 06310	
<div style="display: flex; justify-content: space-between;"> S-163 72 06310 </div>				CERTIFICATE OF DEATH	
BIRTH NO. STATE OF MARYLAND - DEATH			1. NAME OF DECEASED (Type or Print) James Douglass Shepperd		
2. DATE AND HOUR OF DEATH June 29, 1972			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3402 Hillen Road		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 902 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3402 Hillen Road			5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10-2-1890 9. AGE (In years lost birthday) 81 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician 10B. KIND OF BUSINESS OR INDUSTRY Retired 11. BIRTHPLACE (State or foreign country) Bristol Tenn. & Va. 12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Henry Shepperd			14. MOTHER'S MAIDEN NAME Sarah Jane Gott		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War I			16. SOCIAL SECURITY NO. 214-44-7278 17. INFORMANT Mrs. Gladys B. Shepperd ADDRESS 3402 Hillen Rd		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 412.3 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Parkinsonism			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Anterior subarachnoid hemorrhage 5 yrs. Generalized Anterior subarachnoid hemorrhage Parkinsonism ? 1967		
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (the hospital) attended the deceased from June 16 to June 29 1972, that (I) (we) lost saw the deceased alive on June 28 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Walter Shervington M.D.			23B. DATE SIGNED 6/30/72		
23C. PHYSICIAN'S NAME (Type) E. Walter Shervington			23D. ADDRESS M. D. 2301 Harlem Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-1972		24C. NAME OF CEMETERY OR CREMATORY Arbutus Meorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972 25B. NAME OF REGISTRAR Lidney Johnston 25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE			

7-520 72 06311
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF MARYLAND
BIRTH NO. 72 06311

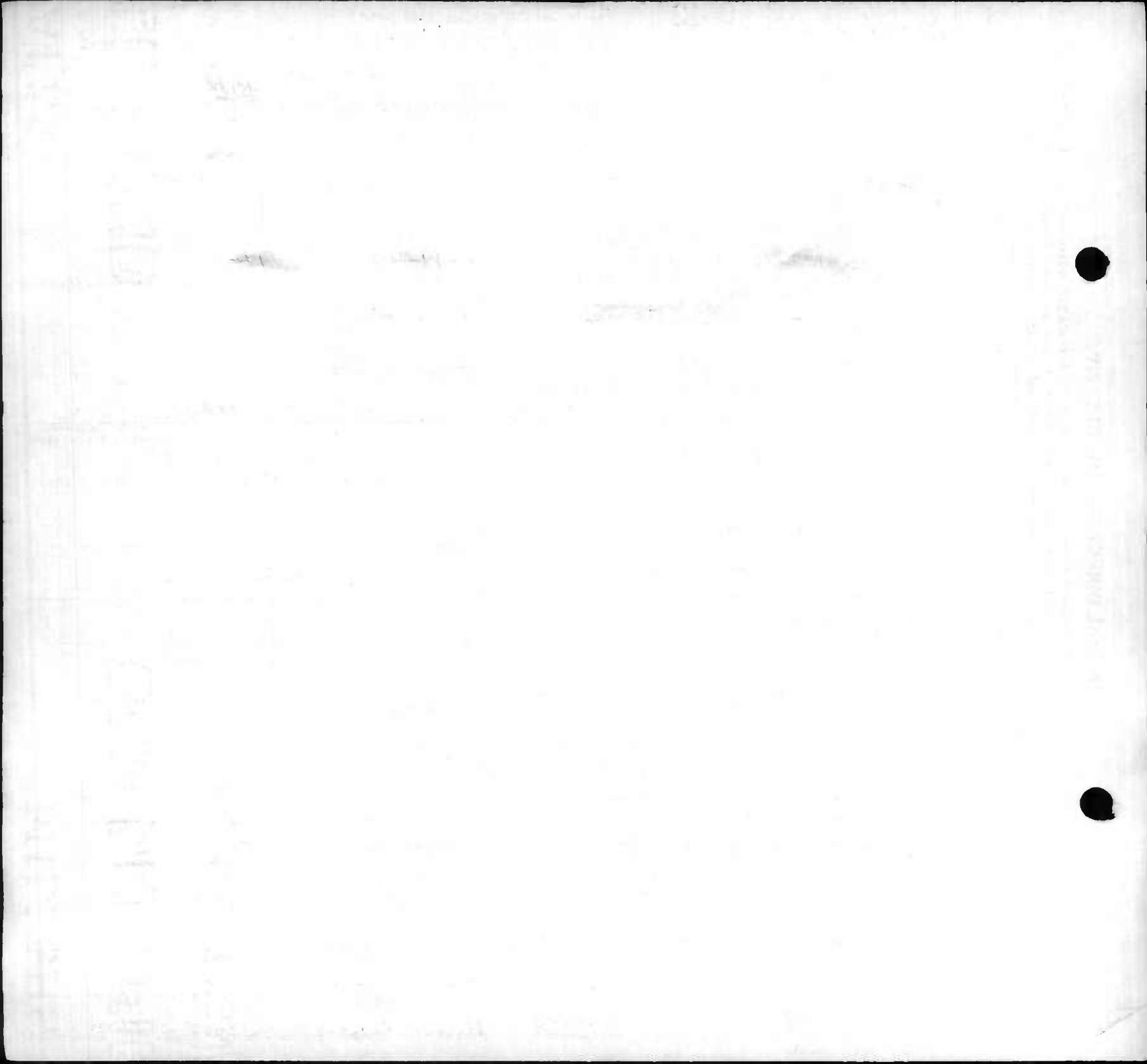
1. NAME OF DECEASED (Type or Print) EARL WALDORF THOMAS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1121 Springfield Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour July 3, 1972 3:50 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2759			
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 7-29-1909		10. AGE (In years last birthday) 62 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 1121 Springfield Avenue
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Benjamin Thomas
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chauffeur		14B. KIND OF BUSINESS OR INDUSTRY Retired	15. MOTHER'S MAIDEN NAME Alice Bantham
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-01-2598	18. INFORMANT ADDRESS Mrs. Beulah M. Thomas 1121 Springfield Ave
19. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 7/4/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-1972	
24C. NAME of CEMETERY or CREMATORY Arbutus Meorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE		ADDRESS	

WALLLEY POLING

FUNERAL DIRECTOR: IMPORTANT

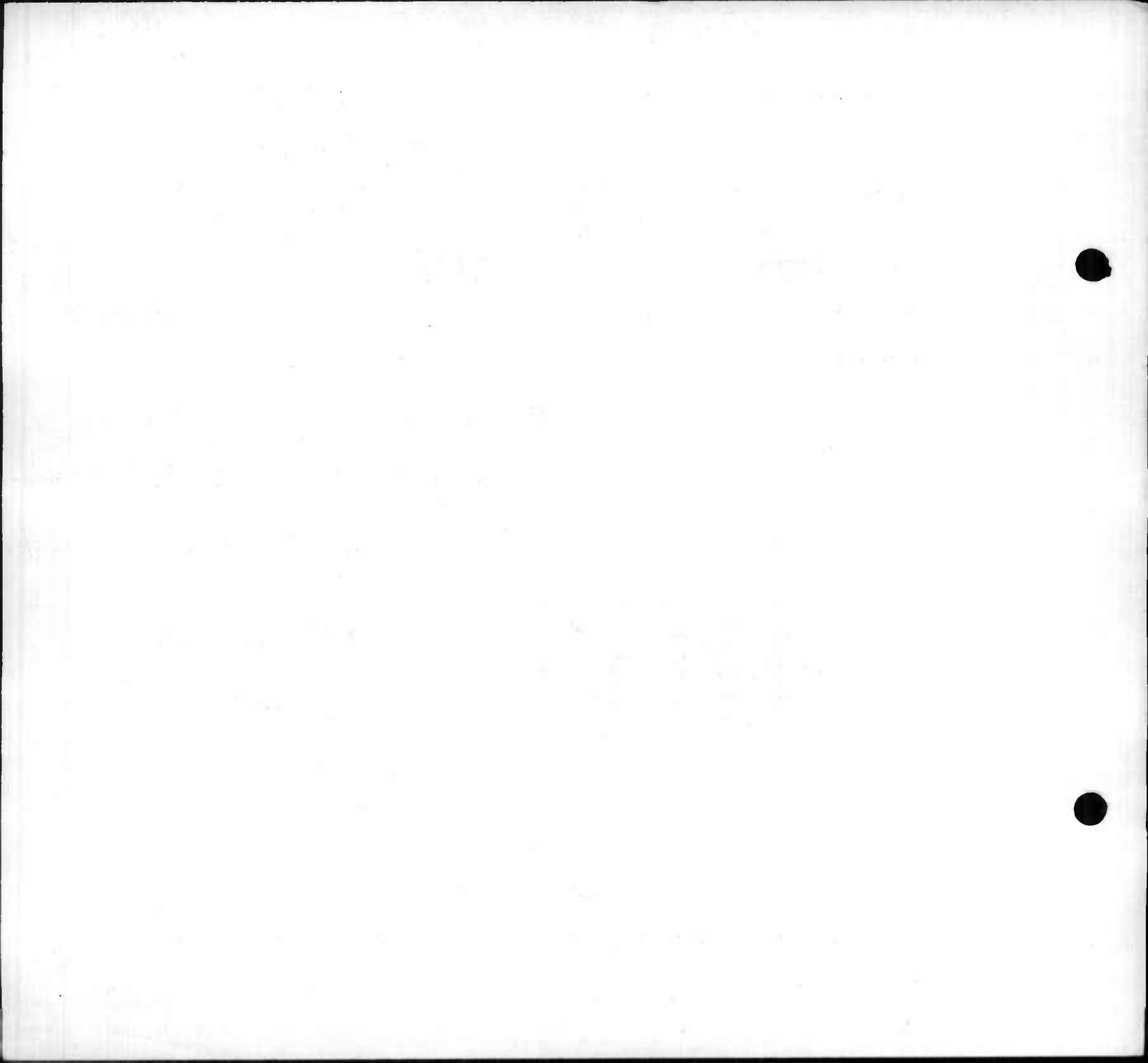
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 72 66312		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 66312	
BIRTH NO. STATE OF MARYLAND-DHMH					
1. NAME OF DECEASED (Type or Print) <u>Theona Brooks</u>			2. DATE AND HOUR OF DEATH <u>June 30, 1972</u> <u>8:45 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>97 Provident Hospital Inc.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2037</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>313 N. Monastery Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-97</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>
13. FATHER'S NAME <u>James Smith</u>			14. MOTHER'S MAIDEN NAME <u>Lydia Brickhouse</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-3906</u>	17. INFORMANT <u>Gladys Gross 313 Monastery Ave.</u>		
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiorespiratory Arrest</u> (B) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD ; Atherosclerotic Bleeding</u>		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ofelia G. Looze M.D.</u>			23B. DATE SIGNED <u>6-30-1972</u>		23C. PHYSICIAN'S NAME (Type) <u>Ofelia G. Looze M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>7-6-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbuzus Memorial Park</u>
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUL 7 1972</u>			25B. NAME OF REGISTRAR <u>Admiral</u>		25C. FUNERAL DIRECTOR <u>Nutshell Federal Home 3035 W. North Ave.</u>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-345 72 06313		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 06313 REG. NO.	
BIRTH NOTATE OF MARYLAND - DEATH					
1. NAME OF DECEASED (Type or Print) HELEN G. WOODLAND			2. DATE AND HOUR OF DEATH 7/3/72 3P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY 1703		
FULL NAME OF HOSPITAL OR INSTITUTION House - in - the - Pines 90 (Belvedere)			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1205 Myrtle Ave.					
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/83	9. AGE (in years last birthday) 88	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY HOME		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Hezekiah Russell			14. MOTHER'S MAIDEN NAME Catherine Gilles		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-48-3347		
17. INFORMANT Dr. George F. Woodland			ADDRESS 10131 Goodbody C		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Columbia, Maryland Myocardial Infarction 5 min. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Dis. unk. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Generalized Arteriosclerosis					
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) no			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4/18/72 to 7/3 19 72 that (I) (we) last saw the deceased alive on 7/3 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stewart, M.D.			23B. DATE SIGNED 7/3/72		
23C. PHYSICIAN'S NAME (Type) D. W. STEWART, M.D.			23D. ADDRESS 2300 Garrison Blvd.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-1972		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore		24E. CITY, TOWN, or county Maryland		24F. STATE Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Andrew Thornton		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEMO		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06314	
BIRTH NO. 72 06314		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) KOMINSKI, MILTON R.		2. DATE AND HOUR OF DEATH July 6, 1972 11:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE MARYLAND B. COUNTY 104	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 519 S. Collington Ave		5. SEX MALE 6. RACE CAUCASIAN 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/15/15 9. AGE (In years last birthday) 57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Quality Control		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PETER KOMINSKI		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 212-07-2416		17. INFORMANT CLIN RCDS, VAH, BALTIMORE, MARYLAND	
18. 203X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE MULTIPLE MYELOMA		MONTHS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) PNEUMONIA		2 days	
		(C) RENAL FAILURE		MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0 N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 12, 1972 to July 6, 1972 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 6, 1972 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) NOT view the body after death.					
23A. SIGNATURE Lawrence Mills M.D.		23B. DATE SIGNED 7/6/72		23C. PHYSICIAN'S NAME (Type) LAWRENCE MILLS, M.D.	
23D. ADDRESS VA HOSPITAL, BALTIMORE, MARYLAND 21218		23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		23F. ADDRESS 401 S. Chester St Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-10-72		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY BALTO MD.	
24D. LOCATION (City, town, or county) BALTO MD.		24E. NAME OF REGISTRAR WEBER FUNERAL HOME		24F. ADDRESS 401 S. Chester St Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Webster		25C. FUNERAL DIRECTOR 401 S. Chester St Balto., Md.	

72 06315 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BENNIE L. HOUSTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 6, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 6, 1972 8:00 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2301			
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 4-8-15		10. AGE (In years lost birthday) 57	E. STREET AND NUMBER 941 S. Sharp Street
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Robert Houston
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Md. Paper Box Co.	15. MOTHER'S MAIDEN NAME Addie Price Houston
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes #2		17. SOCIAL SECURITY NO. 213-20-9644	18. INFORMANT ADDRESS Mrs. Ollie Vinson 1614 Gorsuch Ave. 21218
19. CAUSE OF DEATH E880X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebro-αranial injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? 941 S. Sharp Street 2301			
22D. TIME OF INJURY (APPROX.) 7-5-72 8:30 P. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Apparently fell down stairs			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 6, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-1972	24C. NAME of CEMETERY or CREMATORY Gettysburg National
24D. LOCATION (City, town, or county) (State) Gettysburg, Pa.			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Sidney W. Jones	25C. FUNERAL DIRECTOR ADDRESS Marshall W. Jones, Jr., 1735 Harford Ave. 21213

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
1917

U.S. DEPARTMENT OF AGRICULTURE
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WASHINGTON, D. C.
1917

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
1917

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

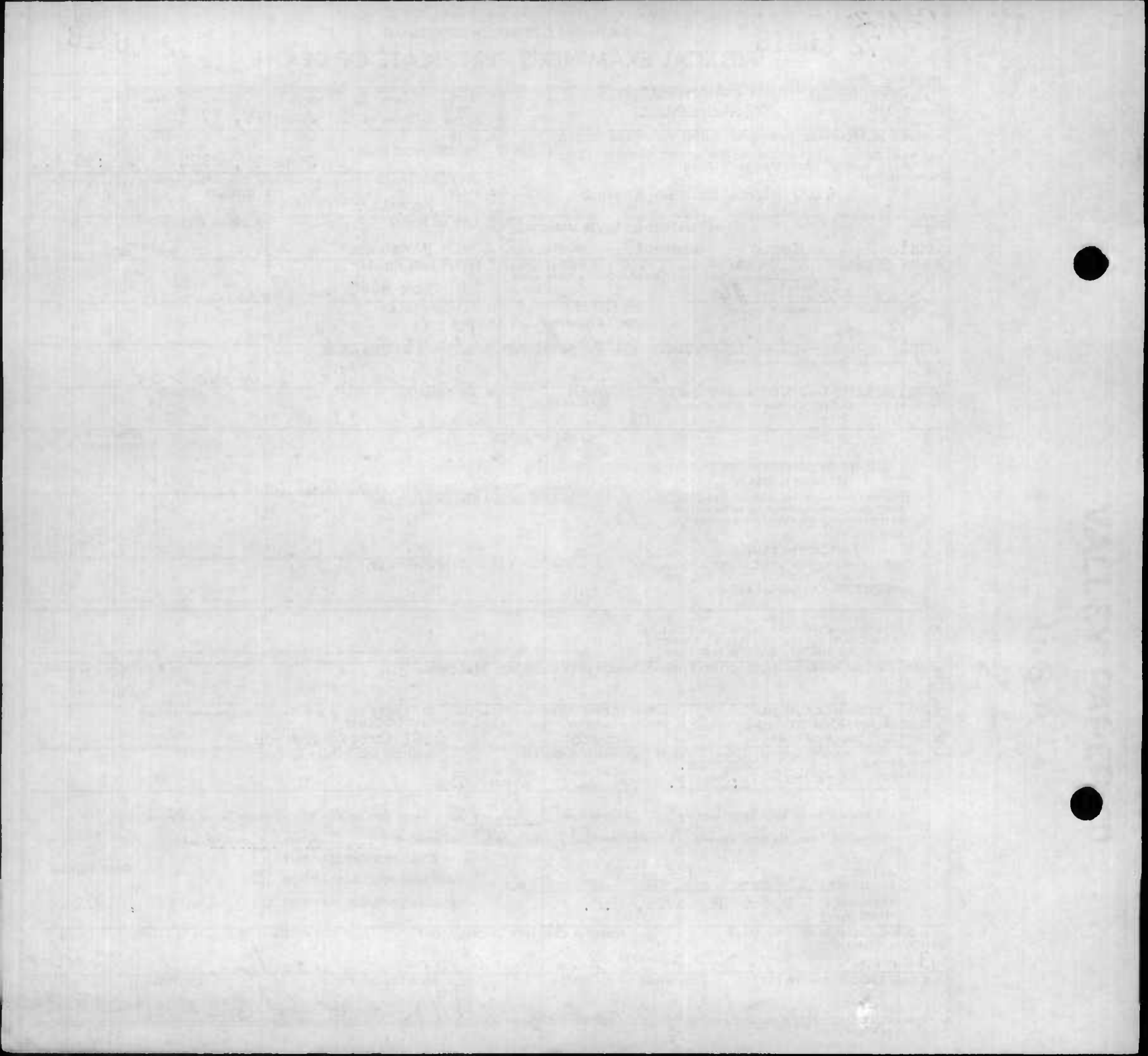
REG. NO.

S-162
72 66316

BIRTH NO. *72 66316* STATE OF *MARYLAND* DEPT. *72 66316*

1. NAME OF DECEASED (Type or Print) DONALD SPEARS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 29, 1972	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 4100 block Curtis Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1972 3:45 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Pasadena	
9. DATE OF BIRTH Sept. 15, 1955		10. AGE (In years last birthday) 16	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY None	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Isabelle Mahoney		18. INFORMANT Isabelle Mahoney	
19. E985X		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) auto	
22D. TIME OF INJURY (APPROX.) 6-29-72 approx. 3:35 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4101 Curtis Avenue		22F. HOW DID INJURY OCCUR? ?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-72	
24C. NAME OF CEMETERY or CREMATORY MT. Zion Meth. Ch. Cem.		24D. LOCATION (City, town, or county) (State) Pasadena Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Adrian Whitlock	
25C. FUNERAL DIRECTOR Elmer D. Wilson		ADDRESS 1000 Brantley Ave. Balt. Md.	

VS 151-REV. 1/1/68



C-452
72 06317

BALTIMORE CITY HEALTH DEPARTMENT

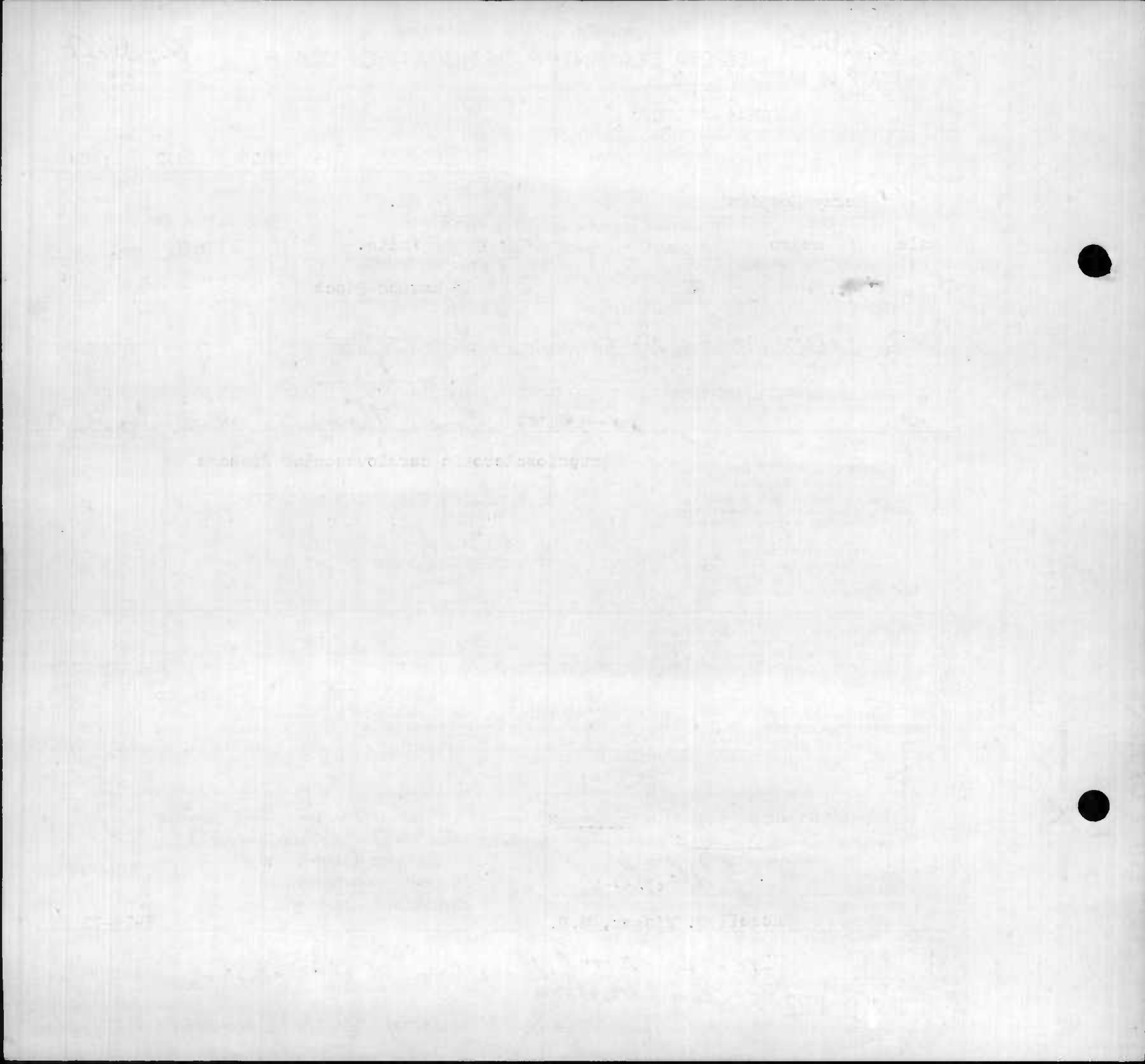
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06317

BIRTH NAME STATE OF MARYLAND-DEME

REG. NO.

1. NAME OF DECEASED (Type or Print) JAMES COLLINS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 26 1972 6:40a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 421	
9. DATE OF BIRTH May 5, 1905		10. AGE (In years last birthday) 67	
11. BIRTH PLACE (State or foreign country) West. Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 308-10-0556	
18. INFORMANT Naomi Thompson		ADDRESS 651 Sterling St.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) NO	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-26-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-72	
24C. NAME OF CEMETERY or CREMATORY MT. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Brooklyn Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Andrew M. Wilson	
25C. FUNERAL DIRECTOR Elmer G. Wilson		ADDRESS 1000 Brimley Ave	



1 E-152 72 Q6318

BALTIMORE CITY HEALTH DEPARTMENT

72 Q6318

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

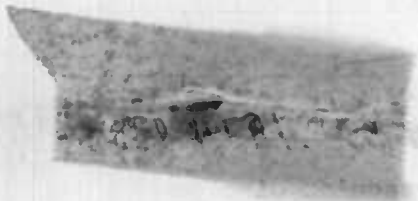
BIRTH STATE OF MARYLAND-DEMD

1. NAME OF DECEASED (Type or Print) OTIES EVANS (Evans)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1914 Barclay Street		3. DATE PRONOUNCED DEAD Month Day Year Hour July 4, 1972 10:45 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1204			
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Jan 7, 1916		10. AGE (In years and birthday) 66	
11. BIRTH PLACE Lawrenceville, VA.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes and unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 234-26-2047	
17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		18. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Tuberculosis			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/5/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-72	
24C. NAME OF CEMETERY or CREMATORY Baltimore Nat. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE RECEIVED BY HEALTH DEPT. JUL 1 1972		25B. FUNERAL DIRECTOR E. O. Wilson	
25C. ADDRESS 1000 Brantley Ave. Balto. Md.			

8100, S.

8100, S.

WILLIAM H. HARRIS, JR., M.D.



WILLIAM H. HARRIS, JR., M.D.

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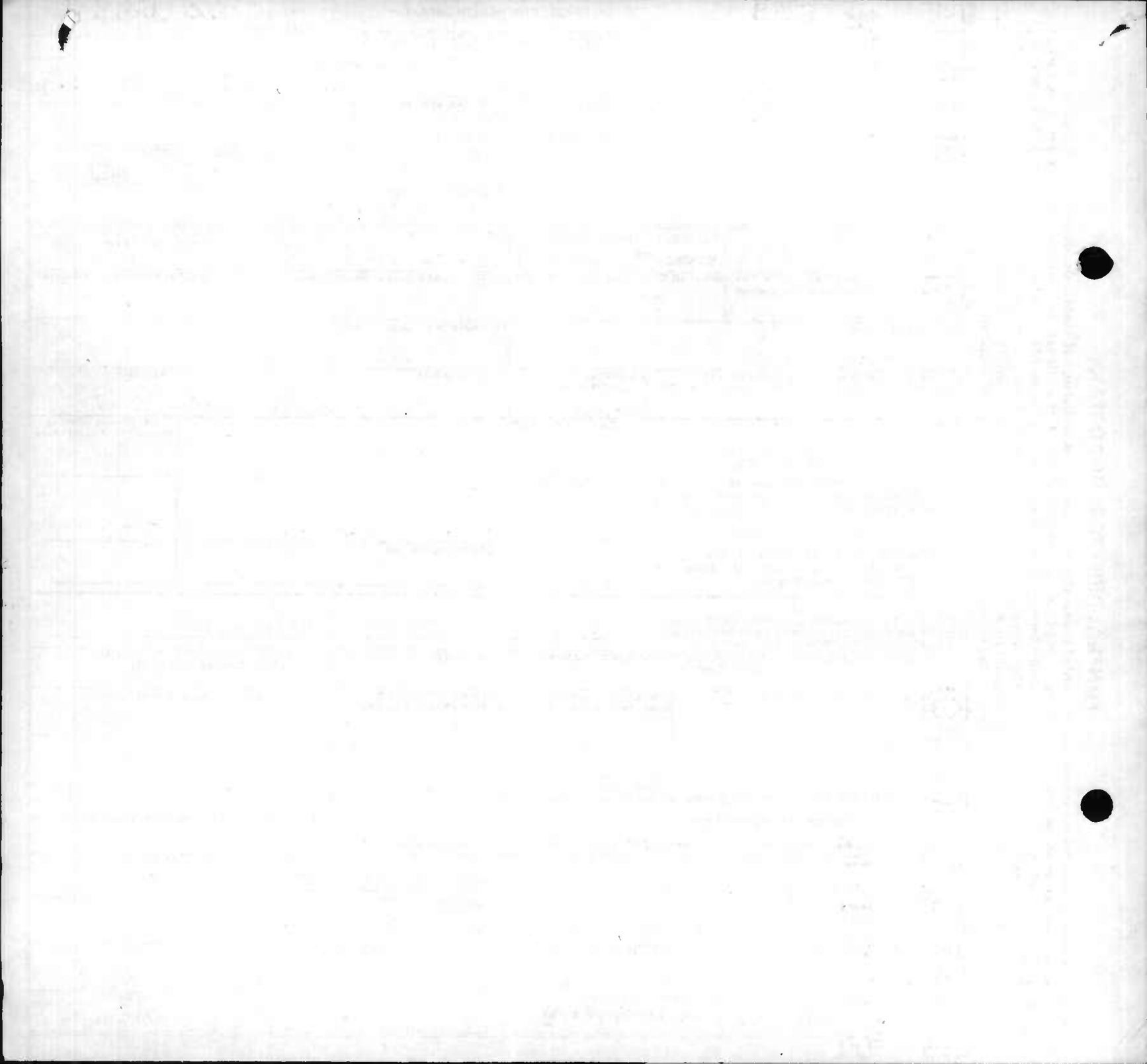


WILLIAM H. HARRIS, JR., M.D.

FUNERAL DIRECTOR: IMPORTANT

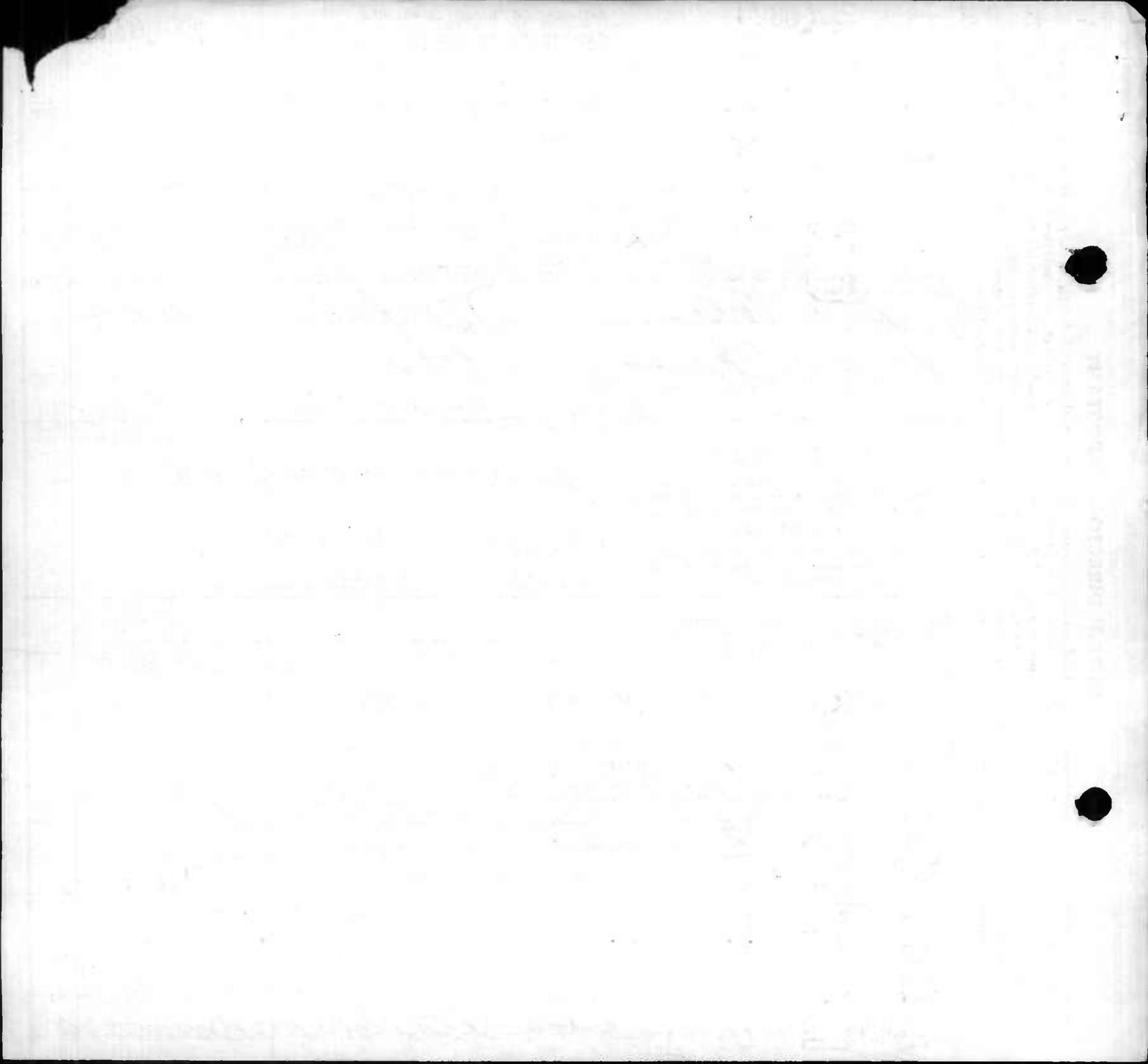
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 Q6319		BALTIMORE CITY HEALTH DEPARTMENT		72 Q6319
BIRTH NO. STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH		REG. NO.
1. NAME OF DECEASED (Type or Print) EVANS, JOHN		2. DATE AND HOUR OF DEATH July 1, 1972 3:30 a. m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY 808		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1246 N. BAY ST.		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-26-18	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) USA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Manley Evans		
14. MOTHER'S MAIDEN NAME Julia Fowler		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 241-36-7957		17. INFORMANT Tamie E. Cradle 1107 Calvin St. N.C.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHRONIC RELAPSING PANCREATITIS		CAUSE OF DEATH CARDIO-RESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HEPATIC ENCEPHALOPATHY LAENNAEC'S CIRRHOSIS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) >10 years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6/17/72 1972 to 7/1 1972 that (I) (we) lost saw the deceased alive on 7/1 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death.				
23A. SIGNATURE Ronald Ginsberg MD		23B. DATE SIGNED 7/1/72		23C. PHYSICIAN'S NAME (Type) Ronald Ginsberg, M.D.
23D. ADDRESS The Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7-7-72		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Brooklyn Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Andrew Wilson		25C. FUNERAL DIRECTOR Cherry D. Wilson 1000 Brantley Ave.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

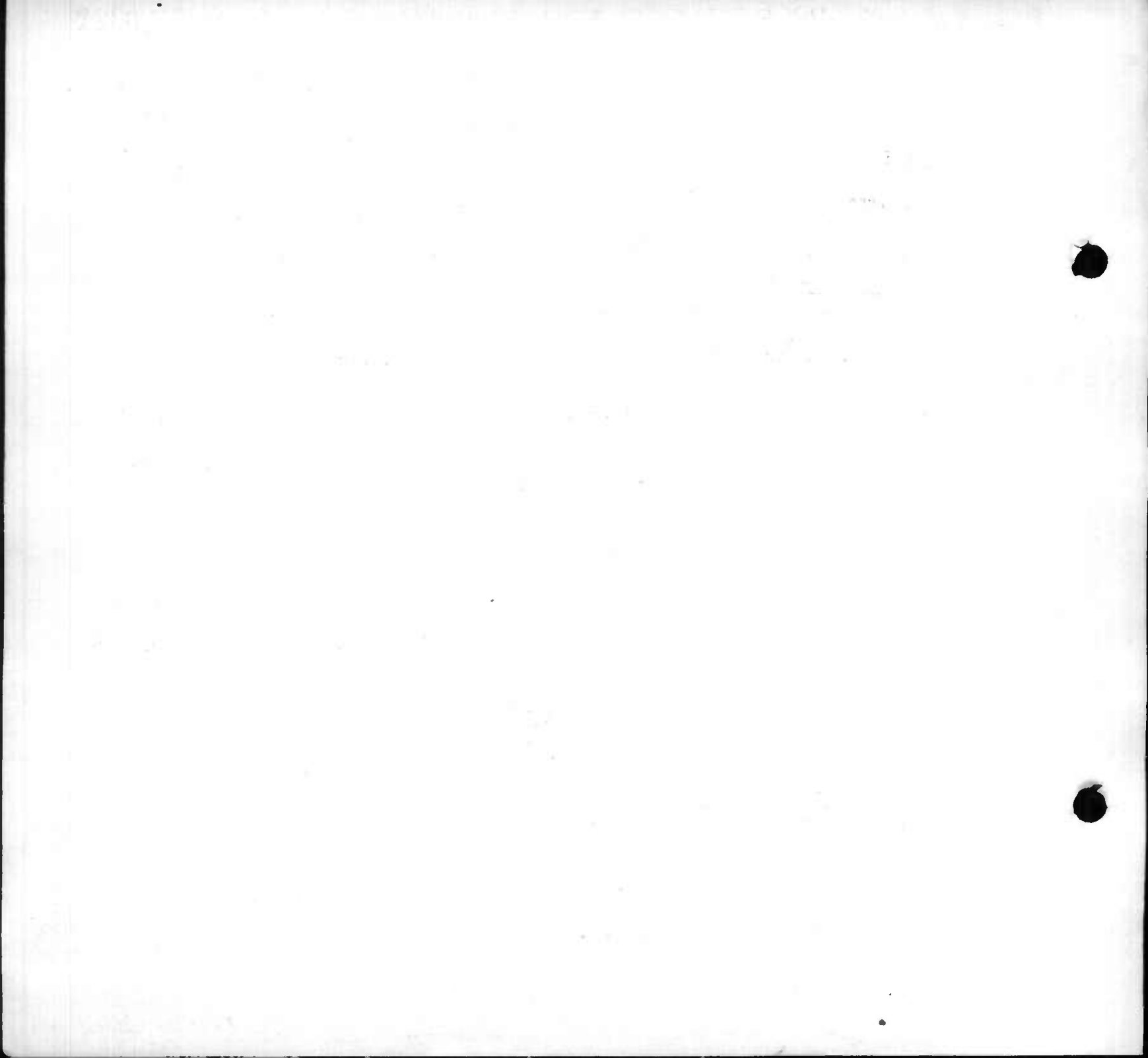
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06320	
C-20072 6320					
CERTIFICATE OF DEATH					
BIRTH NO. STATE OF MARYLAND - DEMH		1. NAME OF DECEASED (Type or Print) <u>Isiah Chase Theodore</u>			
2. DATE AND HOUR OF DEATH <u>July 2, 1972 8:08pm</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u>		B. COUNTY <u>1607</u>	
<u>31</u> BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2910 Riggs Avenue</u>					
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-12</u>	9. AGE (In years last birthday) <u>60</u>	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Edward Chase</u>		14. MOTHER'S MAIDEN NAME <u>Ethel</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-7992</u>		17. INFORMANT <u>BCH-Records</u> ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) IMMEDIATE CAUSE <u>cor. diopulmonary or rest</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(B) <u>septic shock and Klebsiella bacteraemia</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <u>and pneumonia</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 20</u> 19 <u>72</u> to <u>July 2</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>July 2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Marilee C.S. Cole M.D.</u> DEGREE				23B. DATE SIGNED <u>July 2, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>Marilee C.S. Cole M.D.</u> DEGREE		23D. ADDRESS <u>Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-6-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Abraham Lincoln</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. (State) <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1972</u>		25B. NAME OF REGISTRAR <u>Audrey Whitton</u>		25C. FUNERAL DIRECTOR <u>Donaldson</u> ADDRESS <u>1000 Mount Airy</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 06321
BIRTH NO. STATE OF MARYLAND-DEMH		1. NAME OF DECEASED (Type or Print) William Craig (SILAS)		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH July 1, 1972 8:40 P.		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Good Samaritan Hospital 4-5		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1506 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2933 Clifton Avenue		
5. SEX M	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-79	9. AGE (in years last birthday) 92
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Charles Co. Md.
13. FATHER'S NAME Tom E. Craig		12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-01-7892		17. INFORMANT Wife
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) disease Arteriosclerotic heart DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Necrotizing dermatosis		1 month		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) this hospital		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6-28-1972 to 7-1-1972 that (I) (we) last saw the deceased alive on July 1, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Michael Colvin M.D.		23B. DATE SIGNED 7/1/72		23C. PHYSICIAN'S NAME (Type) Michael Colvin, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1972		25B. NAME OF REGISTRAR Shirley H. Wilson		25C. FUNERAL DIRECTOR Elroy O. Wilson
24D. LOCATION (City, town, or county) Brooklyn		24E. ADDRESS 1324 H. Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
Dorchester, Md. 72 06322		REG. NO. 72 06322	
CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Tammy Shorter		2. DATE AND HOUR OF DEATH 7/3/72 6¹⁰ am M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md B. COUNTY Dorchester C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 601 W. Broadway	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 0	If Under 1 Yr. Months 4 Days 7
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) md	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Shorter		14. MOTHER'S MAIDEN NAME MAXINE Coffin Shorter	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT James Shorter		ADDRESS Cambridge R. f. D. #2 MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GI hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GI perforation, 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: Multiple Congenital Anomalies	
19A. DATE OF OPERATION 3/3 & 5/18		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Multiple congenital anomalies	
20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3/2 19 72 to 7/3 19 72 that (we) last saw the deceased alive on 7/3 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE James L. Robertson MD		23B. DATE SIGNED 7/3/72	
23C. PHYSICIAN'S NAME (Type) James L. Robertson MD		23D. ADDRESS JH H	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/72	
24C. NAME OF CEMETERY OR CREMATORY Dor. Memorial Park		24D. LOCATION (City, town, or county) (State) Cambridge Dor. MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1972		25B. NAME OF REGISTRAR Dorothy Johnson	
25C. FUNERAL DIRECTOR LeCompte Funeral Home, Cambridge MD		ADDRESS	

Rt. #1

Cambridge, Md.

110

C-120

72 06323

BALTIMORE CITY HEALTH DEPARTMENT

72 06323

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. STATE OF MARYLAND-DEMR

1. NAME OF DECEASED (Type or Print) CLARENCE M. CEPHAS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 4, 1972 1:00 A. M.	

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
A. STATE Maryland	B. COUNTY 1607
6. SEX Male	7. RACE Negro
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

9. DATE OF BIRTH 3/11/20	10. AGE (In years last birthday) 52	11. BIRTHPLACE (State or foreign country) Federalsburg, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME N/A
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14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Rebecca Cephas
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16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) Yes 8/28/43 - 12/17/45	17. SOCIAL SECURITY NO. 219-01-0543	18. INFORMANT Mr. Marvin F. Magee	ADDRESS Washington, D.C. 1126 48th Place, N.E.
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19. 430191 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	CAUSE OF DEATH Intracerebral hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rupture of aneurysm of Circle of Willis (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) yes
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22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED 7/4/72	

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/8/72	24C. NAME of CEMETERY or CREMATORY Zion A.M.E. Ch. Cem.	24D. LOCATION (City, town, or county) (State) Federalsburg, Maryland
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25A. DATE REC'D BY HEALTH DEPT. JUN 7 1972	25B. NAME OF REGISTRAR Sidney H. Gordon	25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens Street
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7/19/72 - Letter from Medical Examiner's Office, Dr. Kornblum.

ABC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 66328	
B-250 72 66328					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Mr. George T. Boykin			2. DATE AND HOUR OF DEATH 7-5-72 4²⁰ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2001 C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1929 W. Lexington St		
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-05-23	9. AGE (in years last birthday) 48	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mech. o.p.		10B. KIND OF BUSINESS OR INDUSTRY Beth Steel	11. BIRTHPLACE (State or foreign country) Clinton, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Pressie Boykin			14. MOTHER'S MAIDEN NAME MARY Sykes		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11/4/43 - 3/14/46			16. SOCIAL SECURITY NO. 42 235-40 440		17. INFORMANT Chart
18. 42491 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARDIAC VALVULAR DISEASE			(B) DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCT		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). POSSIBLE DISSECTING ANEURYSM AORTA					
19A. DATE OF OPERATION N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 26 1972 to JULY 5 1972 that (I) (we) last saw the deceased alive on JULY 5 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE FELIX A. SORIA M.D.				23B. DATE SIGNED 7-5-72	
23C. PHYSICIAN'S NAME (Type) FELIX A. SORIA M.D.				23D. ADDRESS BON SECOURS, BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/9/72		24C. NAME OF CEMETERY OR CREMATORY Sand Hill Cemetery	
24D. LOCATION Clinton, N.C.		24E. CITY, TOWN, OR COUNTY (State) N.C.			
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR Morton Dyett F.H.	
				ADDRESS 1701 Laurens St.	

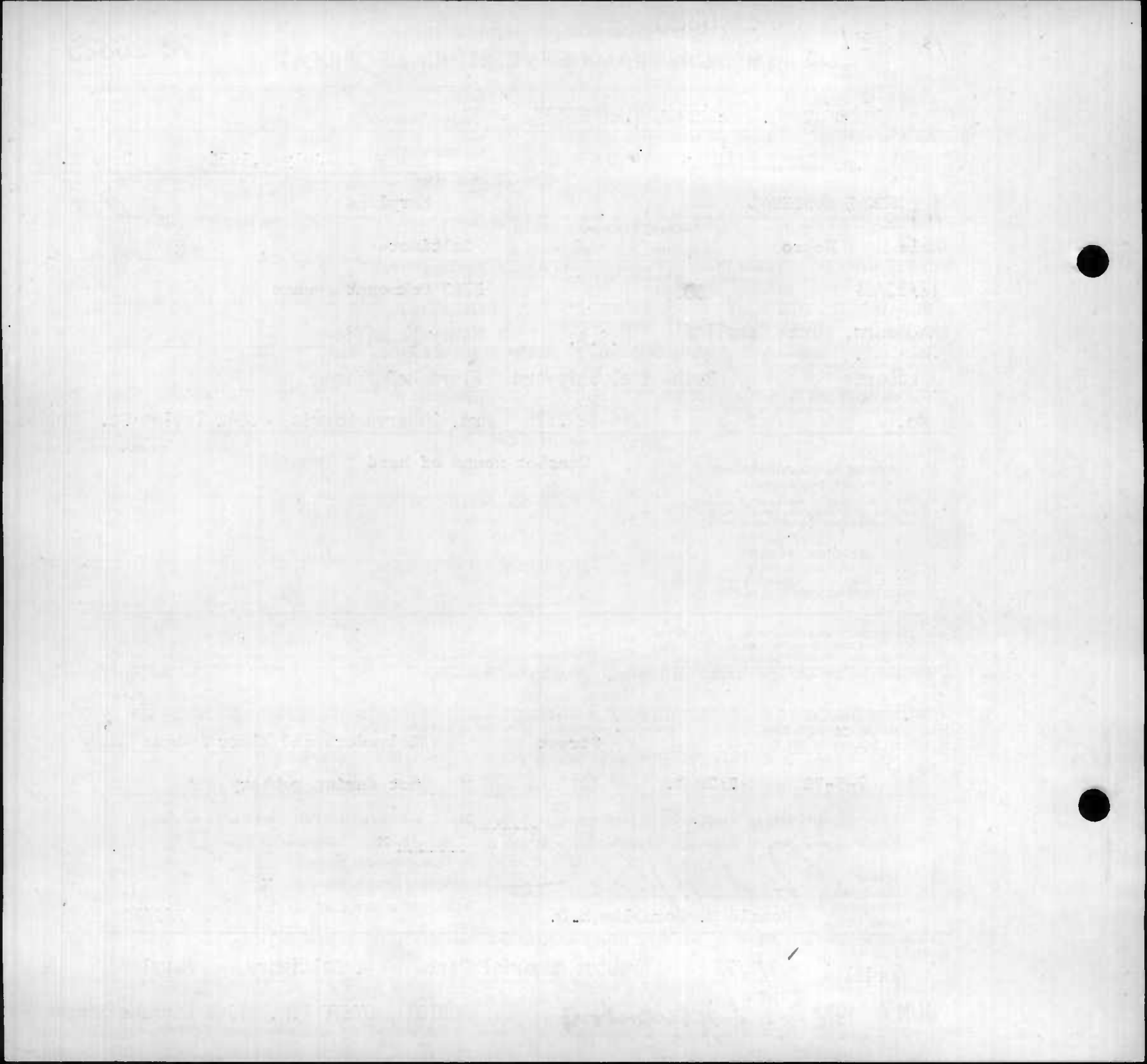
48

Clinton, New York

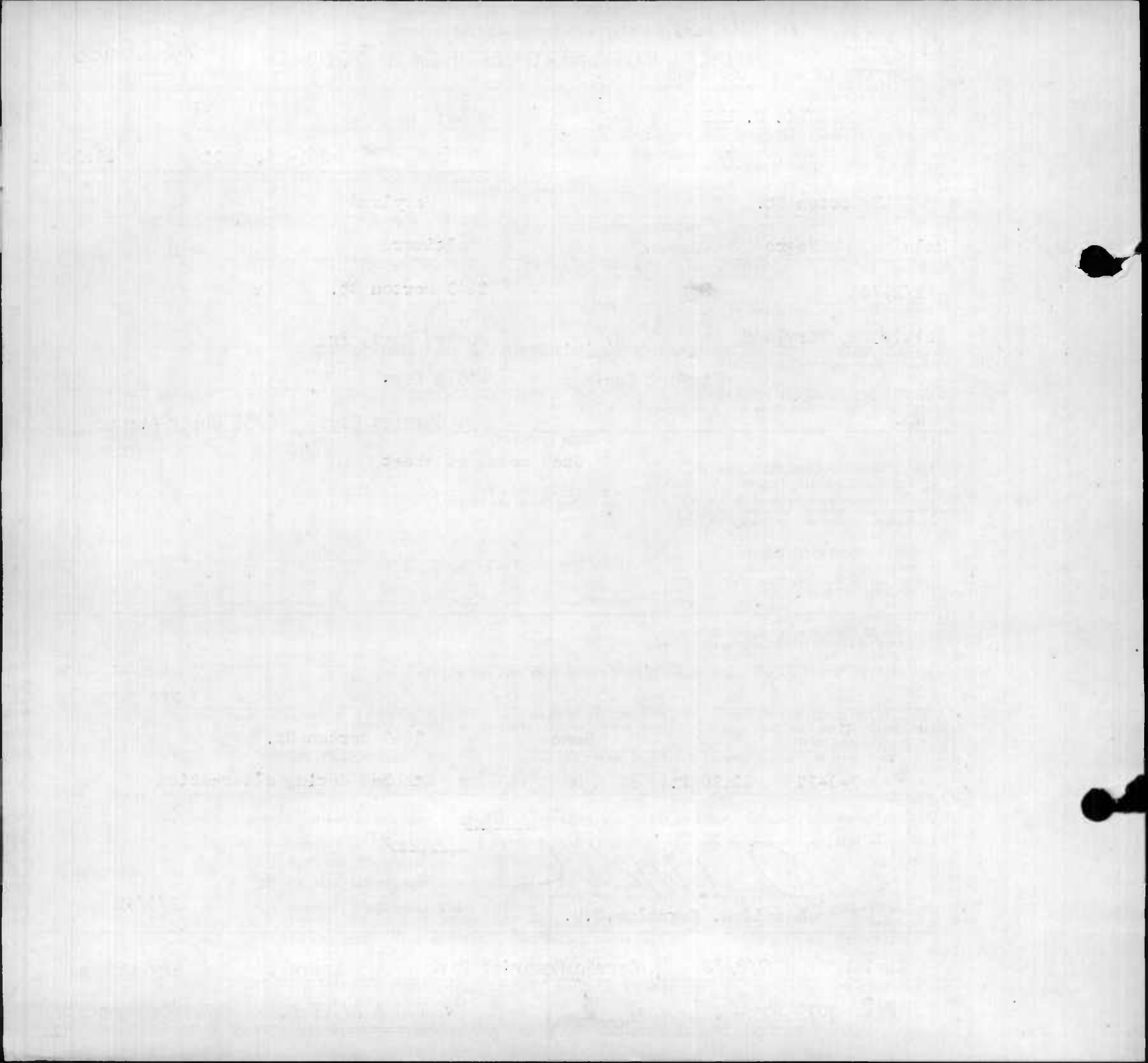
John - 1/10/10

John - 1/10/10
Clinton, New York

BIRTH NO.		STATE OF MARYLAND		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) ROBERT H. McDUFFEY (McDUFFIE)				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1972 2:05 A.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2798			
6. SEX Male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 12/23/21		10. AGE (In years last birthday) 50		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 3703 Oakmount Avenue			
11. BIRTHPLACE (State or foreign country) Chadbourn, North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry McDuffie			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				14B. KIND OF BUSINESS OR INDUSTRY Beth-Steel Shipyard		15. MOTHER'S MAIDEN NAME Flora McDuffie			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.				17. SOCIAL SECURITY NO. 244-12-5570		18. INFORMANT ADDRESS Mrs. Minerva Morris 5442 Irving St. Phila., Pa.			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH Gunshot wound of head				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
20A. DATE OF OPERATION 7-5-72				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Belvedere and Elmer Avenue 2798			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-5-72 2:20 A.m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during robbery			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7/5/72	
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1972				25B. NAME OF REGISTRAR <i>Sidney W. Houston</i>		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens Street			



BIRTH NO.		STATE OF MARYLAND-DHMH		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) EUGENE R. KEYES (Keys)				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2443 Dorton Ct.				3. DATE PRONOUNCED DEAD July 4, 1972		Month Day Year		Hour M. 11:30 P.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2543				6. SEX Male 7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 12/21/43		10. AGE (In years lost birthday) 28		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Howard Keys, Sr.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Comfort Springs				14B. KIND OF BUSINESS OR INDUSTRY Comfort Springs		15. MOTHER'S MAIDEN NAME Viola Keys			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr. Charles Keys 2701 Uhler Avenue			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Stab wound of chest				CAUSE OF DEATH Stab wound of chest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2443 Dorton Ct. 2543			
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 7-4-72 11:30 P. m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed during altercation			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				ACTUAL SIGNATURE Ronald N. Kornblum, M.D.				DATE SIGNED 7/5/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72		24C. NAME of CEMETERY or CREMATORY Carver Memorial Park		24D. LOCATION (City, town, or county) (State) Laurel, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1972		25B. NAME OF REGISTRAR Sidney H. Hoston		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69-02558 72 06327		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06327	
BIRTH NO. STATE OF MARYLAND-DEM		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DAVIS GWENDOLYN		2. DATE AND HOUR OF DEATH JULY 5 / 72 4/50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF MARYLAND HOSPITAL 38		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1753 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 900 ARGYLE AV. BALTO. MD 21201			
5. SEX FEMALE	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-69	9. AGE (In years last birthday) 3	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME TIMOTHY NMI DAVIS		14. MOTHER'S MAIDEN NAME VINETTA WHITE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS VINETTA WHITE - 900 ARGYLE AV.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEPTICAEHIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: AC. MONOCYTIC LEUKEMIA (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6-20-72 1972 to 7/5/1972 that (I) (we) last saw the deceased alive on JULY 5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Atesic, M.D.		23B. DATE SIGNED 7/5/72			
23C. PHYSICIAN'S NAME (Type) MATESIC, M.D.		23D. ADDRESS UNIV. OF MD - HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT JUN 7 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett F.H. 1701 Laurens St.	

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2. 1. 1841

2. 1. 1841

FUNERAL DIRECTOR: IMPORTANT

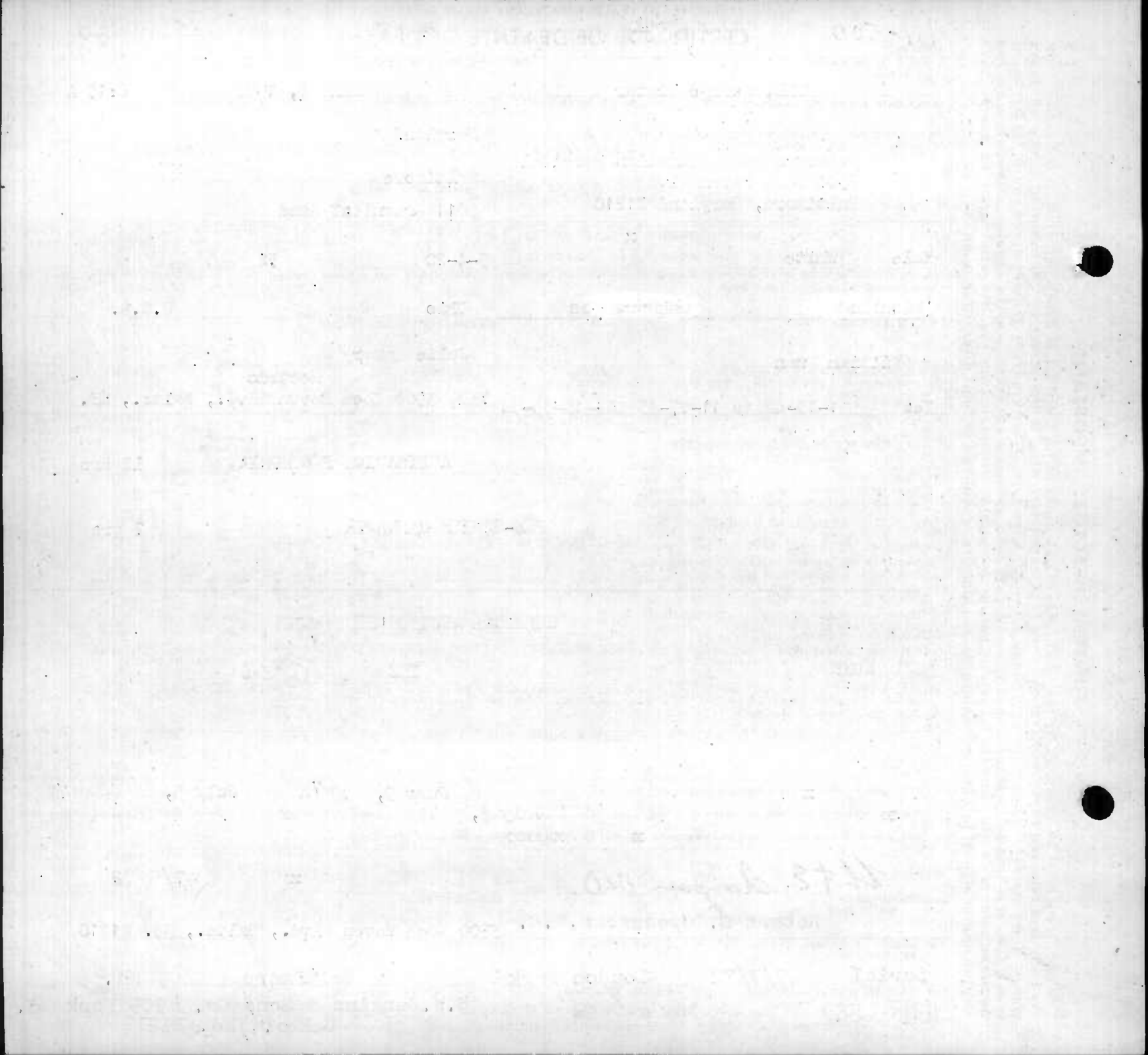
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-420		72 66328		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 66328	
BIRTH NO. STATE OF MARYLAND-DHMH				1. NAME OF DECEASED (Type or Print) <i>James M. Ellis</i>			
2. DATE AND HOUR OF DEATH <i>7/5/72 11:50 AM</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Baltimore Md</i> B. COUNTY <i>1604</i>			
5. SEX <i>male</i> 6. RACE <i>Negro</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>5/15/27</i> 9. AGE (In years last birthday) <i>45</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stock Clerk</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Standard Supply Co.</i>			
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>				12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>			
13. FATHER'S NAME <i>Clarence Ellis</i>				14. MOTHER'S MAIDEN NAME <i>Nora Susan Jacobs</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes. 3/9/46 - 9/5/47</i>				16. SOCIAL SECURITY NO. <i>219-22-9556</i>			
17. INFORMANT <i>Mrs. Bertha Ellis</i>				ADDRESS <i>1912 Lauretta Ave.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, which rise to the above cause (A) stating the UNDERLYING CONDITION last.				A) IMMEDIATE CAUSE <i>BRAIN STEM CONTUSION</i> DUE TO, OR AS A CONSEQUENCE OF: <i>1 week</i>			
B) DUE TO, OR AS A CONSEQUENCE OF:				C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				19A. DATE OF OPERATION <i>7/5/72</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>REMO. YES</i>			
20A. AUTOPSY? (Yes or No) <i>YES</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>3-6-00</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>STREET</i>			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>1604</i>				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>5 29 72 10:20</i>			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR? <i>3 driver gear not working road hit low rail</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>5/29</i> 19 <i>72</i> to <i>7/5</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>7/5</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <i>A. Schuppisser</i> 23B. DATE SIGNED <i>7/5/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>SCHUPPISSE JEAN PIERRE</i>				23D. ADDRESS <i>UNIV. OF MD. HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>7/11/72</i>			
24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Park</i>				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 7 1972</i>				25B. NAME OF REGISTRAR <i>John W. Hinton</i>			
25C. FUNERAL DIRECTOR <i>Morton Dyer F. H.</i>				ADDRESS <i>1701 Laurens St.</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> M-500 72 06329 CERTIFICATE OF DEATH REG. NO. 72 06329 </div>			
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		July 5, 1972 6:15 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Munn, George Victor		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN	
Veterans Administration Hospital		Baltimore	
3900 Loch Raven Blvd		D. INSIDE CITY LIMITS?	
Baltimore, Maryland 21218		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		8. DATE OF BIRTH	
Male		5-4-20	
6. RACE		9. AGE (In years last birthday)	
White		52	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		If Under 1 Yr. Months: Days	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Banker		Ohio	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Mortgages		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Munn		Julie Hamory	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		17. INFORMANT	
Yes		Records	
1-15-42 to 11-27-45		ADDRESS	
16. SOCIAL SECURITY NO.		VAH, 3900 Loch Raven Blvd., Balto., Md.	
264-16-35-56			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		12 hrs	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		ASPIRATION PNEUMONIA	
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		2 yrs	
(B) PRE-SENILE DEMENTIA			
(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		SURGICAL ADDISON'S DISEASE	
19A. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)	
NONE		YES	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (H) (this hospital) attended the deceased from June 9, 1972 to July 5, 1972		21F. HOW DID INJURY OCCUR?	
that (H) (we) last saw the deceased alive on July 5, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Robert E. Greengear M.D.		7/5/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Robert E. Greengear, M.D.		3900 Loch Raven Blvd., Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24D. LOCATION (City, town, or county) (State)	
Burial		Baltimore Md.	
24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
7/7/72		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25C. FUNERAL DIRECTOR	
JUN 7 1972		H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	
25B. NAME OF REGISTRAR		ADDRESS	
Audrey W. Horton			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-652 72 06330		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06330	
BIRTH NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Mehring, John H.</u>			2. DATE AND HOUR OF DEATH <u>7-5-72</u> <u>2:25 pm</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Union Memorial Hosp. 33rd + Calvert St.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Baltimore, Md.</u> B. COUNTY <u>21239</u> <u>2738</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hosp.</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>8-06-1871</u> 9. AGE (In years last birthday) <u>100</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Pittsburgh Glass Co.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>Phillip Mehring</u>			14. MOTHER'S MAIDEN NAME <u>MARY Riddle</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-05-5131A</u>		17. INFORMANT <u>MISS MARGARET E MEHRING</u> ADDRESS <u>(SAME)</u>
18. <u>54871</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Aspiration Pneumonia or Pulmonary Embolism</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized Debility 20 to Age and possible underlying Neuro-muscular disease.</u>			(B) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>- Probable Pneumococcal Pneumonia</u> <u>- Depressed Respiratory Drive.</u>			(C) _____		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 29</u> 19 <u>72</u> to <u>July 5</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>July 5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alan N. Lieberman</u> DEGREE				23B. DATE SIGNED <u>July 5, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALAN N. LIEBERMAN</u> DEGREE				23D. ADDRESS <u>3306 N. Calvert St. Balt. Md. 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/7/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 7 1972</u>			
25B. NAME OF REGISTRAR <u>Sidney H. Horton</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212</u>			

CONFIDENTIAL

1963

CONFIDENTIAL

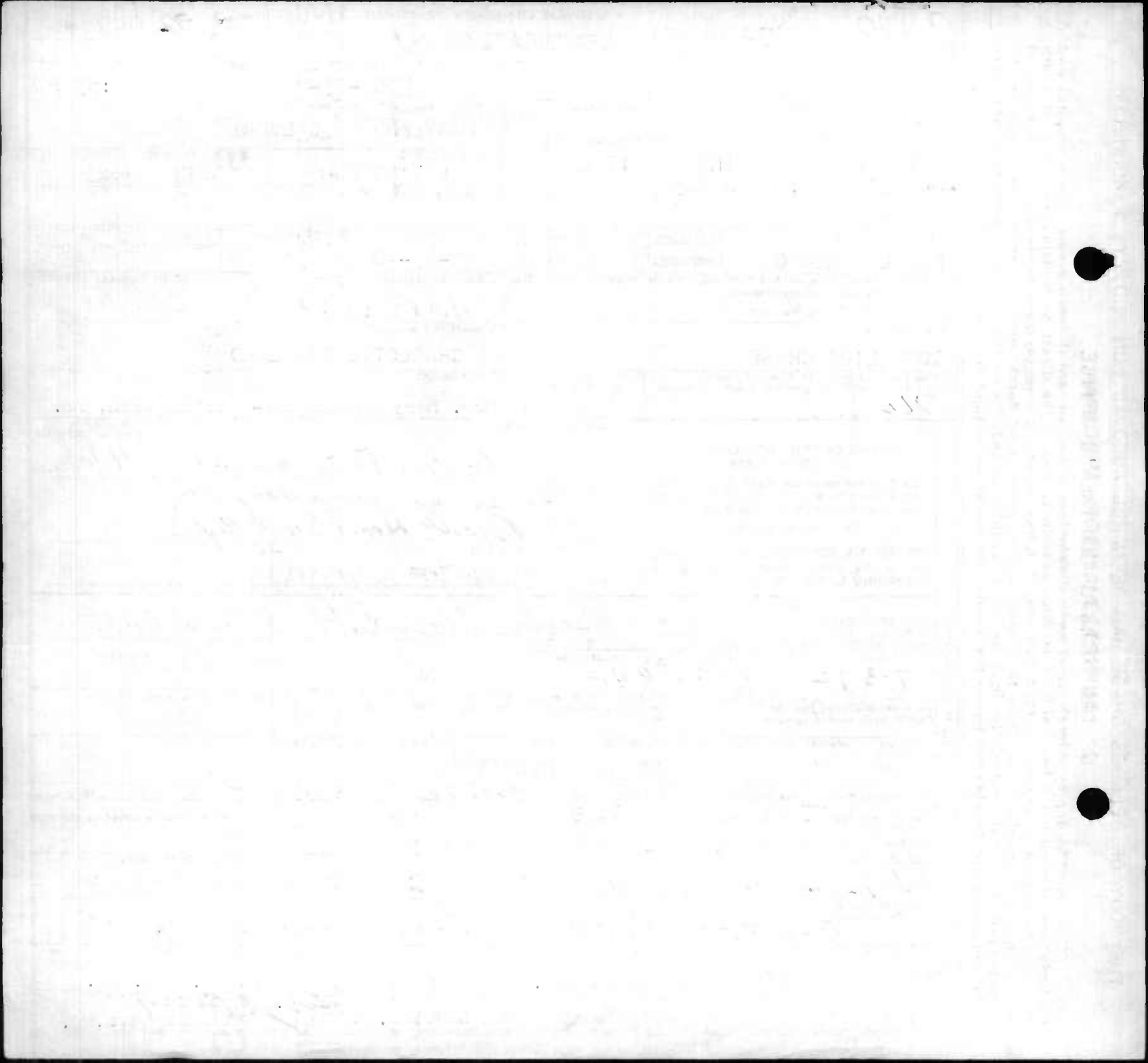
CONFIDENTIAL
PAGE 10

CONFIDENTIAL

OF THE FUNERAL DIRECTOR: **IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200		72 06331		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06331	
BIRTH NO. STATE OF MARYLAND - DEATH				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DELORES CHASE				2. DATE AND HOUR OF DEATH 07-03-72		3:55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY CALVERT		5400	
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION JOHNS HOPKINS HOSPITAL 33 BALTIMORE, MD 21205				C. CITY OR TOWN HUNTINGTOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER				5. DATE OF BIRTH 11-25-40		9. AGE (in years last birthday) 31	
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) Calvert Co. Md.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CORNELIUS CHASE				14. MOTHER'S MAIDEN NAME CHARLOTTE FREELAND			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary Washington - Huntingtown, Md.	
18. 394.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiac Paralysis → unable to come of Cardiac Resp. Par. (B) 2 nd Open Heart Surg (Replace of mitral valve) (C) Severe Rheumatic Heart Dis w/ CHF.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hours	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 17-3-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe CHF		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-1-72 1972 to 7-3 1972 that (I) (we) last saw the deceased alive on 7-3-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles Pappas MD.				23B. DATE SIGNED 7-3-72			
23C. PHYSICIAN'S NAME (Type) CHARLES PAPPAS				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72		24C. NAME of CEMETERY or CREMATORY Patuxent Chr. Cemetery		24D. LOCATION (City, town, or county) (State) Huntingtown, Md. Cal. Co.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Leroy E. Berry		25C. FUNERAL DIRECTOR LEROY E. BERRY Huntingtown, Md.			



1

72 06332

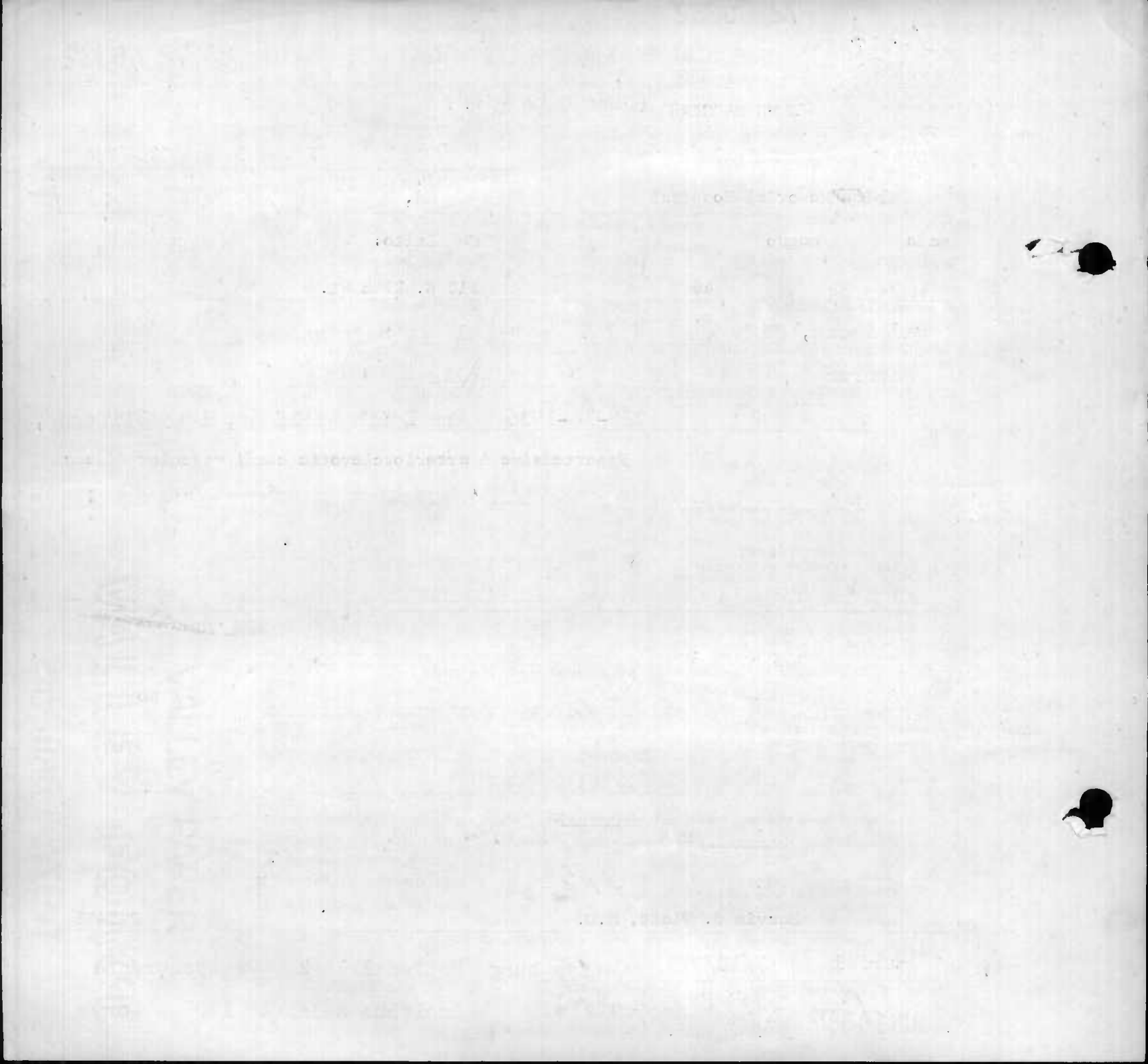
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 06332

BIRTH NO. H-252 STATE OF MARYLAND-DEMR

1. NAME OF DECEASED (Type or Print) JOHN HAGGINS (John C Haggins)		2. DATE DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour
				7	3	1972	2 a
6. SEX male		7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 904	
9. DATE OF BIRTH 10/27/25		10. AGE (In years last birthday) 46		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF U S A	
13. FATHER'S NAME Al Haggins		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Belle		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) yes W W 2	
17. SOCIAL SECURITY NO. 218-16-1716		18. INFORMANT Mrs Edith Williams, 1945 Clifton, A		19. CAUSE OF DEATH Hypertensive & arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 4/12-2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/72		24C. NAME of CEMETERY or CREMATORY Gettysburg National		24D. LOCATION (City, town, or county) (State) ark Gettysburg Pa	
25A. DATE REC'D BY HEALTH DEPT JUN 10 1972		25B. NAME OF REGISTRAR Sidney		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

151-REV. 1/1/68



W-452 72 06333		BALTIMORE CITY HEALTH DEPARTMENT		72 06333	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
STATE OF MARYLAND - DHMH					
1. NAME OF DECEASED (Type or Print) Johnnie (JONNIE) L. WILLIAMS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year July 7, 1972		Hour M. 1:00 P.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
A. STATE Maryland		B. COUNTY 1403			
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
9. DATE OF BIRTH 6-15-13		10. AGE (In years last birthday) 59		E. STREET AND NUMBER 229 Brunt Street	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Baylor Williams	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Lucy Smith	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Henry Williams 715 N. Rosedale St	
19. 412.4 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 7/8/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-72		24C. NAME of CEMETERY or CREMATORY MT Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR ADDRESS Wm C. March 928 E North Ave.	

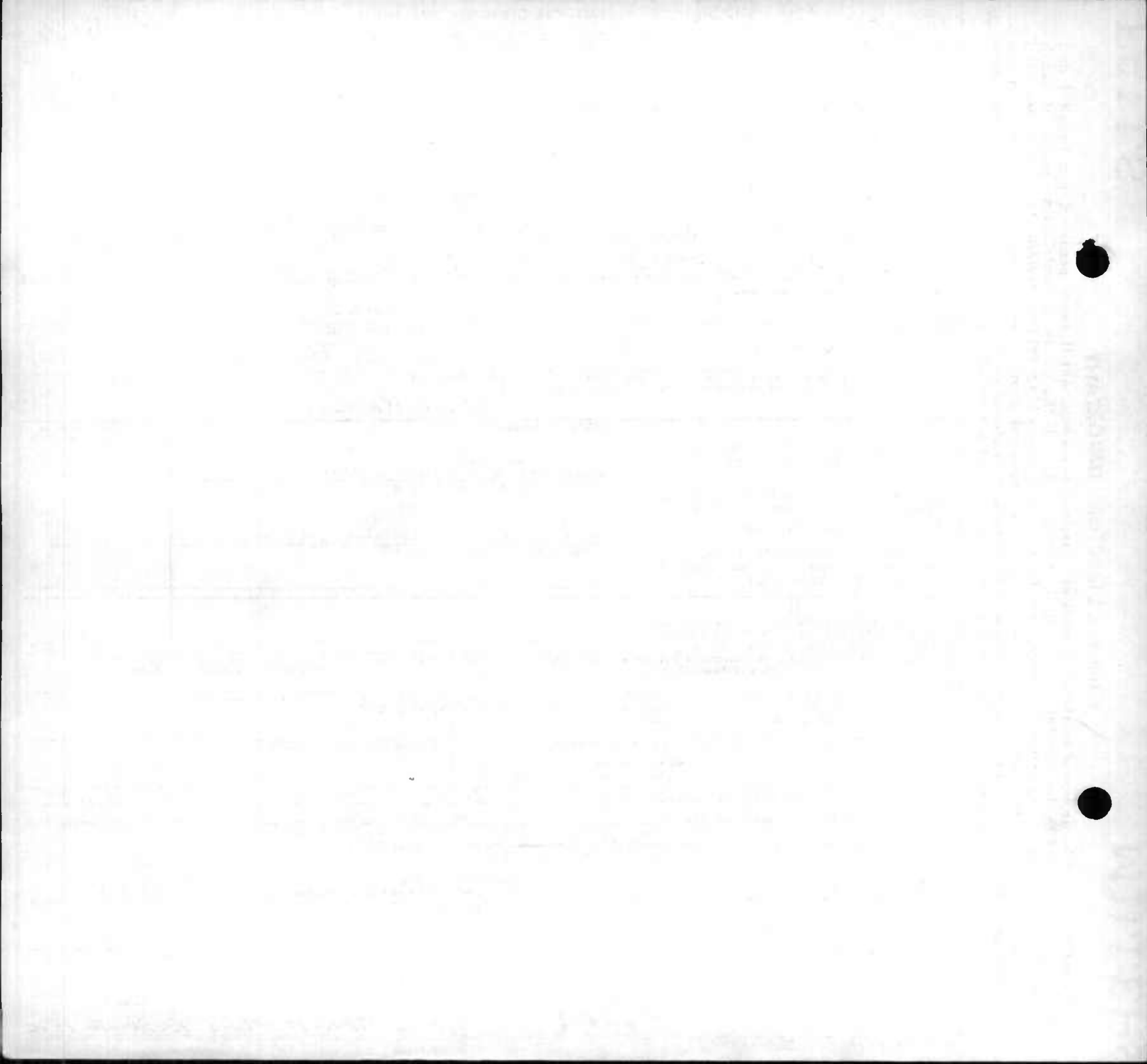
Med. EXam has address

JS 2229 Brunt st.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

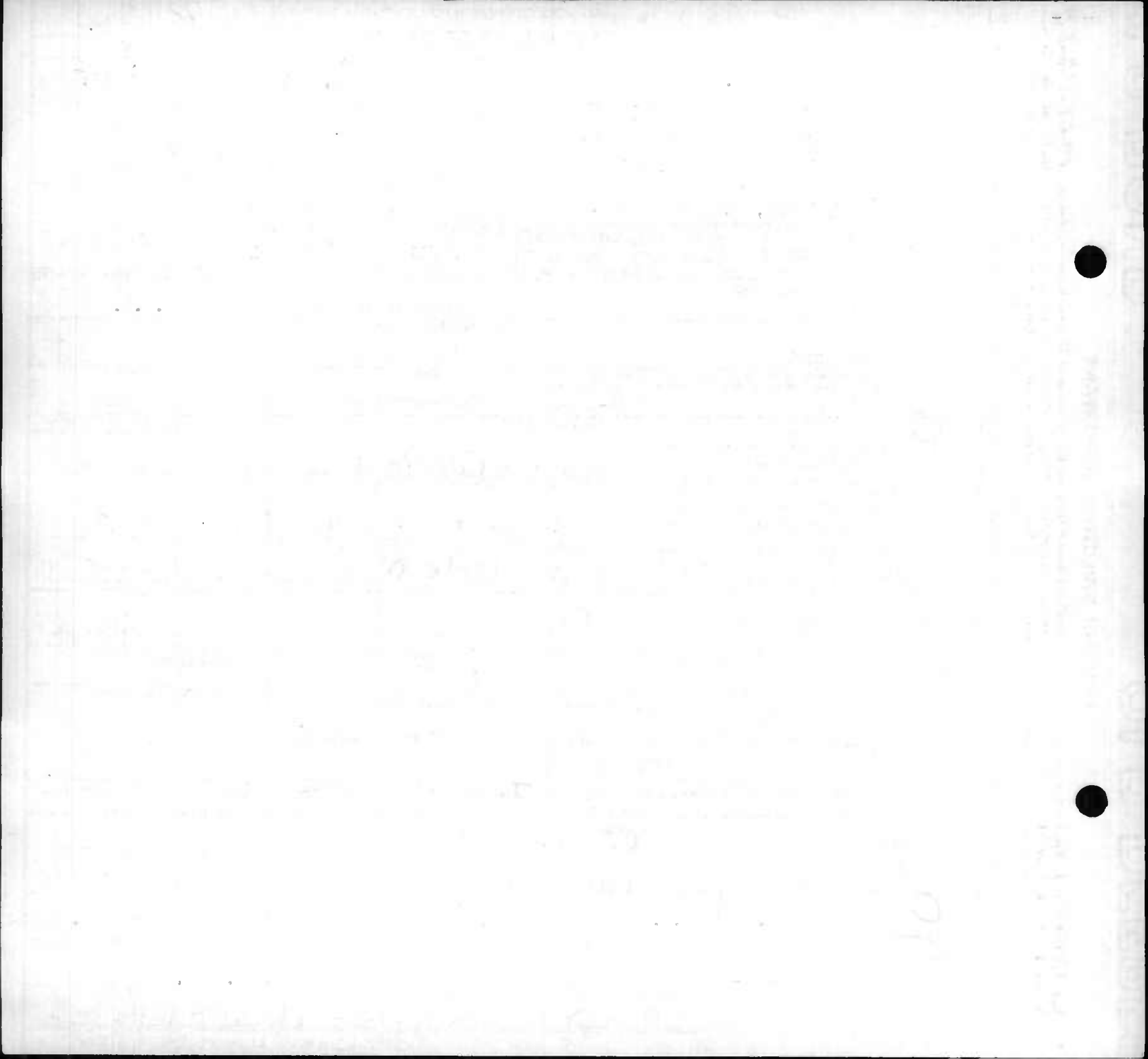
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06334	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <u>M-324</u></p> <p>STATE OF MARYLAND <u>DEMET</u></p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> </div>					
1. NAME OF DECEASED (Type or Print) <u>Emma E. Mitchell</u>			2. DATE AND HOUR OF DEATH <u>7/8/72</u> <u>12 55</u> <u>PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSPITAL</u>			A. STATE <u>MD.</u> B. COUNTY <u>1203</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>2438 BARCLAY ST.</u>		
5. SEX <u>F</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/95</u>	9. AGE (in years last birthday) <u>76</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Isaac Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Booze</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JESSE RANDOLPH</u>	
				ADDRESS	
18. <u>309.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> (B) <u>Chronic Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-7</u> 19 <u>72</u> to <u>7/8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>MB Pearlman</u> MD DEGREE				23B. DATE SIGNED <u>7/8/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>MB PEARLMAN MD</u>				23D. ADDRESS <u>33rd and Calvert Balt Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-12-72</u>		24C. NAME of CEMETERY or CREMATORY <u>BALTO. NATIONAL CEM., BALTO., MD</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>			
		25B. NAME OF REGISTRAR <u>Andrew Whitman</u>		25C. FUNERAL DIRECTOR <u>WM C MARCH</u>	
				ADDRESS <u>928 E. North Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-255 72 66335		BALTIMORE CITY HEALTH DEPARTMENT		72 66335	
BIRTH NO. STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Willie B. Richmond			2. DATE AND HOUR OF DEATH July 8, 1972 11:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE West Virginia V45 B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			C. CITY OR TOWN Beckley		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 908 Terrell Street					
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/8/11	9. AGE (In years last birthday) 61	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sam Richmond		14. MOTHER'S MAIDEN NAME Lula Gordon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 232-16-3944		17. INFORMANT BCH Records 4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 2. 0 3 x 1 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiopulmonary failure minutes DUE TO, OR AS A CONSEQUENCE OF: (B) suspect arrhythmia, ASCVD years DUE TO, OR AS A CONSEQUENCE OF: (C) Multiple Myeloma 2 mos. Chronic Renal failure ? years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) 3 NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 2nd 1972 to July 8 1972 that (I) (we) last saw the deceased alive on July 8 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Paul F. Ryan MD			23B. DATE SIGNED July 8 '72		
23C. PHYSICIAN'S NAME (Type) Paul F. Ryan M.D.			23D. ADDRESS Baltimore City Hospital 4940 Eastern Ave. 21224		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-12-72		24C. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
24D. LOCATION (City, town, or county) (State) Beckley, W. Va.					
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Ritchie + Johnson Fun. Home		25C. FUNERAL DIRECTOR ADDRESS Beckley west Virginia	



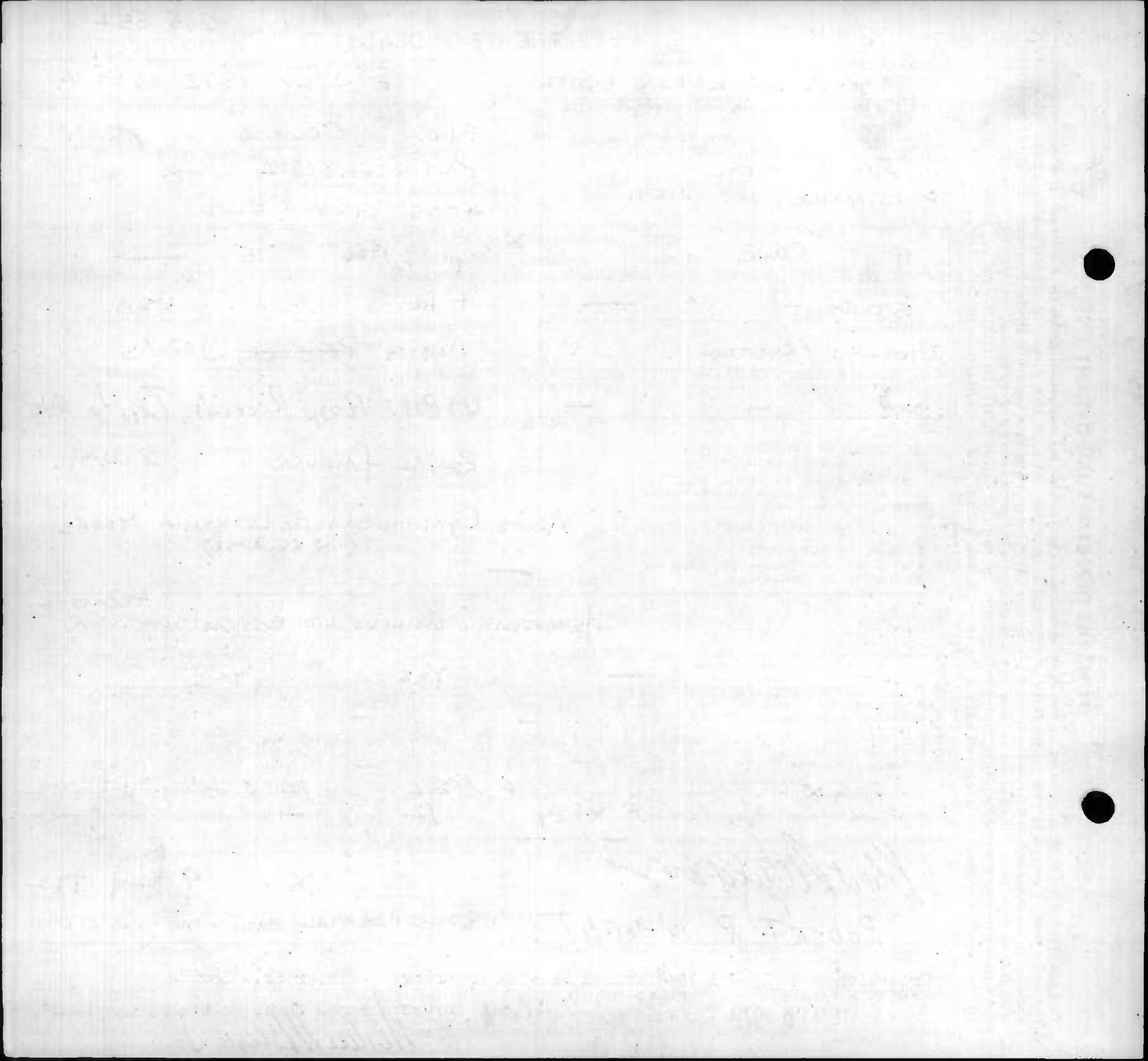
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06336			
A-235 72 06336 MEDICAL EXAMINER'S CERTIFICATE OF DEATH BIRTH STATE OF MARYLAND-DEMD							
1. NAME OF DECEASED (Type or Print) COVERT DANIEL AUSTIN				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour <input type="checkbox"/> Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 304 E. North Avenue				3. DATE PRONOUNCED DEAD Month Day Year Hour July 3, 1972 2:00 P.M.			
6. SEX Male				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1204			
7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH May 3, 1925		10. AGE (in years lost birthday) 47 46x		E. STREET AND NUMBER 304 E. North Avenue			
11. BIRTHPLACE (State or foreign country) Dentsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Stephen R. Austin			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		14B. KIND OF BUSINESS OR INDUSTRY Electrical		15. MOTHER'S MAIDEN NAME Ruth Brigett			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		17. SOCIAL SECURITY NO. 219-16-0199		18. INFORMANT Father: Stephen R. Austin, Weston, W. Va. ADDRESS			
19. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes (partial)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> (Partial) Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/4/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Anthony...		25C. FUNERAL DIRECTOR ADDRESS 21201 STEWART & MOWEN CO. 108 W. North Ave.			

WILLIAM & ROBERT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 72 06337					CERTIFICATE OF DEATH					
REG. NO. 265 552					72 06337					
1. NAME OF DECEASED (Type or Print) PRESTON, KAREN EDITH					2. DATE AND HOUR OF DEATH 8 JULY 1972 6:25 A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE FLA. B. COUNTY ORLANDO					
FULL NAME OF HOSPITAL OR INSTITUTION USPHS HOSPITAL BALTIMORE, MD 21211					C. CITY OR TOWN ORLANDO 3284 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER 4005 GRANT BLD.										
5. SEX F	6. RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1956	9. AGE (In years last birthday) 15	11. Under 1 Yr. Months: Days: Hours: Min.		12. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) FLA.
12. CITIZEN OF WHAT COUNTRY? USA.										
13. FATHER'S NAME Gordon Preston					14. MOTHER'S MAIDEN NAME Annie Preston Jarvis					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. —					
17. INFORMANT USPHS Hosp Records, Balto Md					ADDRESS					
18. CAUSE OF DEATH 204.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). HEMORRHAGIC DIATHESIS WITH POSSIBLE SEPTICEMIA.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS					
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No) Yes					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
21F. HOW DID INJURY OCCUR?										
22. I certify that (this hospital) attended the deceased from 6 APRIL 19 72 to 8 JULY 19 72, that (I) (we) last saw the deceased alive on 8 JULY 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE Robert R. Wright					23B. DATE SIGNED 9 July 1972					
23C. PHYSICIAN'S NAME (Type) Robert R. Wright					23D. ADDRESS USPHS HOSPITAL, BALTIMORE, MD 21211					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation					24B. DATE 13 Jul 72					
24C. NAME OF CEMETERY or CREMATORY Central Florida Crematory					24D. LOCATION (City, town, or county) Winter Pk, Florida (State)					
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972					25B. NAME OF REGISTRAR Audrey H. Horton					
25C. FUNERAL DIRECTOR Burgee Funeral Home, Baltimore Maryland					25D. ADDRESS By: Norma Burgee					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06338	
BIRTH NO. 72 06338 STATE OF MARYLAND - DHMH					
1. NAME OF DECEASED (Type or Print) Russell Butler			2. DATE AND HOUR OF DEATH 7-6-72 9:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2227 B. Prentiss Place		
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-28-36	9. AGE (In years past birthday) 35	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman			10B. KIND OF BUSINESS OR INDUSTRY City of Balto		11. BIRTHPLACE (State or foreign country) Md
13. FATHER'S NAME Norris Butler			14. MOTHER'S MAIDEN NAME Marsha Tyne		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/19/54-7/19/58			16. SOCIAL SECURITY NO. 213-32-3854		17. INFORMANT Thelma Butler ADDRESS 2227 Prentiss Place
18. 201X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Sepsis DUE TO, OR AS A CONSEQUENCE OF: (B) Acute Renal Failure DUE TO, OR AS A CONSEQUENCE OF: (C) Hodgkins Disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Acidosis, Pneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 16 hrs 8 yrs
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 24 19 72 to July 6 19 72 that (I) (we) last saw the deceased alive on July 6 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE RJ Baury M.D. DEGREE			23B. DATE SIGNED 7-6-72		23C. ADDRESS 5 Danhurst Court. Towson
23D. PHYSICIAN'S NAME (Type) RJ Baury DEGREE			23E. ADDRESS 5 Danhurst Court. Towson		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/72		24C. NAME OF CEMETERY or CREMATORY Arlington Mem. Pk	
24D. LOCATION (City, town, or county) Arlington Md.		24E. LOCATION (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Sidney Whitman		25C. FUNERAL DIRECTOR Joseph B. Locks Jr ADDRESS 1304 N. Central	

Dear Sir

I have the honor to acknowledge the receipt of your letter of the 10th inst.

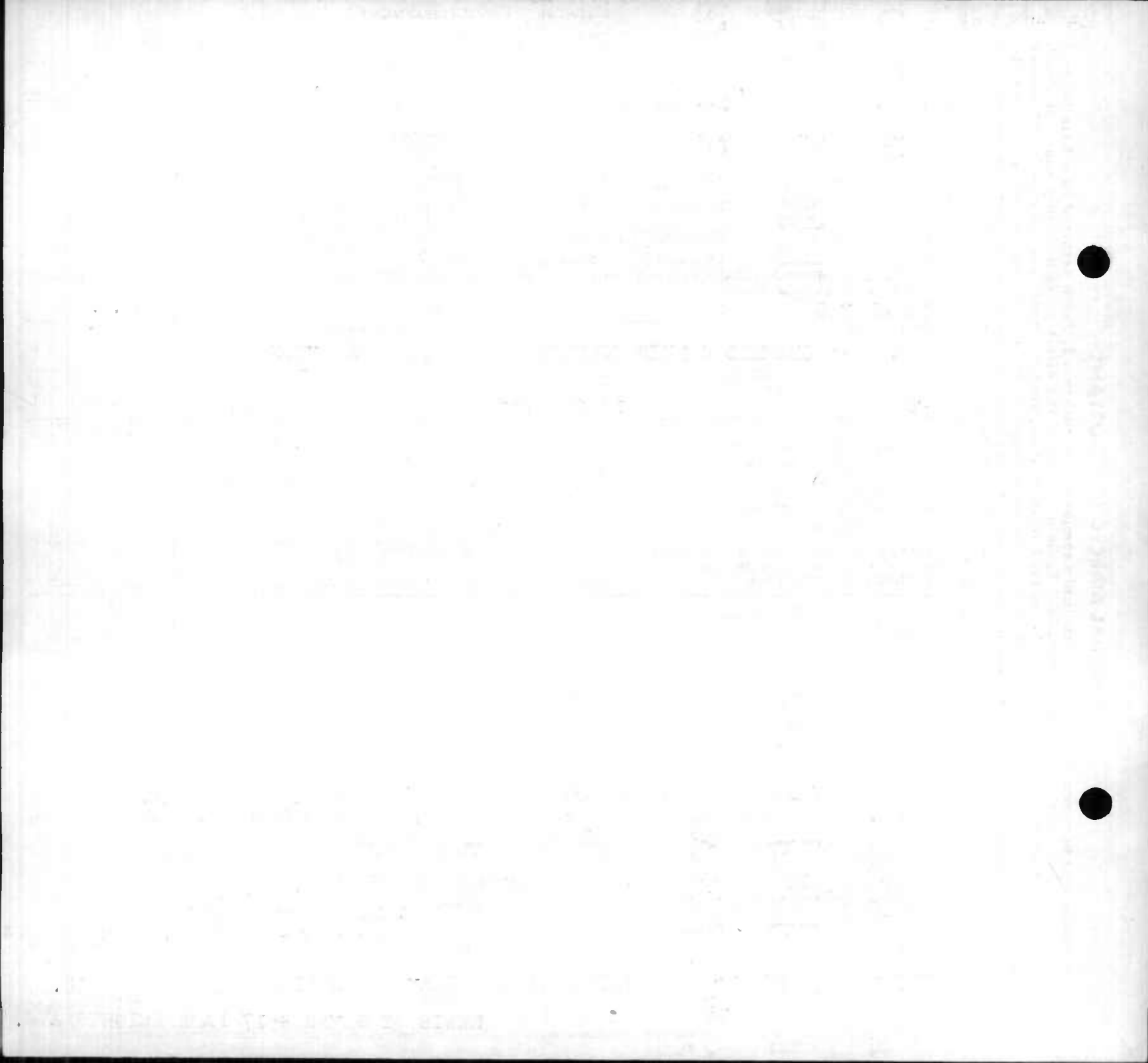
Yours

I am, Sir, very respectfully,
Yours to command

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-164		STATE OF MARYLAND-DHMH		72 06339		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06339	
1. NAME OF DECEASED (Type or Print) Beverly, Hazel				2. DATE AND HOUR OF DEATH June 29, 1972 2:30a M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Avenue 21224				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2037 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 320 Lyndhurst Street					
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/27		9. AGE (In years last birthday) 45		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES CALVIN JOHNSON				14. MOTHER'S MAIDEN NAME Elizabeth HYSON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 216 20 0002		17. INFORMANT BCH-Records ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
18. 400.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTRACEREBRAL HEMORRHAGE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Malignant Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hrs. ? 5 yrs.	
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 6/29 19 72 to 6/30 19 72 that (1) (we) last saw the deceased alive on 6/29 19 72 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did not) view the body after death.									
23A. SIGNATURE Robert L. Ruxin				23B. DATE SIGNED 6/30/72				23C. PHYSICIAN'S NAME (Type) Robert L. Ruxin	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 7/5/72		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY			
24D. LOCATION BALTIMORE				24E. ADDRESS 4940 Eastern Avenue - Baltimore, Maryland 21224		24F. CITY, TOWN, or county (State) MD.			
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972				25B. NAME OF REGISTRAR Lewis T. Gwynn		25C. FUNERAL DIRECTOR LEWIS T. GWYNN			
25D. ADDRESS 4517 PARK HEIGHTS AVE.									



K-625 72 06340				BALTIMORE CITY HEALTH DEPARTMENT				72 06340			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.							
1. NAME OF DECEASED (Type or Print) THOMAS KIRSCHNER, SR.				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour M.							
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 CITY HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1972 12:40 A.M.							
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
9. DATE OF BIRTH SEPT. 23, 1912				10. AGE (In years lost birthday) 59		11. BIRTHPLACE (State or foreign country) MARYLAND					
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME CHARLES H. KIRSCHNER		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE					
15. MOTHER'S MAIDEN NAME MARY E. PYLES				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 213-C9-2774					
18. INFORMANT MARY JANE KIRSCHNER - WIFE				19. ADDRESS SAME ADDRESS		20. CAUSE OF DEATH Multiple Injuries					
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Injuries				22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Multiple Injuries							
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Multiple Injuries				24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Multiple Injuries							
25. DATE OF OPERATION 7-4-72				26. CONDITION FOR WHICH OPERATION WAS PERFORMED Multiple Injuries							
27. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street							
29. TIME (Month) (Day) (Year) (Hour) 7-4-72 10:00 P.m.				30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>							
31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Old N. Point Rd. and McComas Street				32. HOW DID INJURY OCCUR? Driver in auto-auto collision							
33. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				34. ACTUAL SIGNATURE Ronald N. Kornblum, M.D.							
35. DATE SIGNED 7/5/72				36. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
37. BURIAL CREMATION, REMOVAL (Specify) BURIAL				38. DATE 7/6/1972							
39. NAME of CEMETERY or CREMATORY PARK WOOD				40. LOCATION (City, town, or county) (State) BALTO. CO., MD.							
41. DATE REC'D BY HEALTH DEPT. JUN 10 1972				42. NAME OF REGISTRAR Sidney H. ...							
43. FUNERAL DIRECTOR W. R. ...				44. ADDRESS ...							

1/2

OK

Mr. J. H. Johnson
17. Johnson

Oct 23, 1914

Mr. J. H. Johnson
U.S.A. Charles H. Johnson
18th Street, N.W., Wash. D.C.

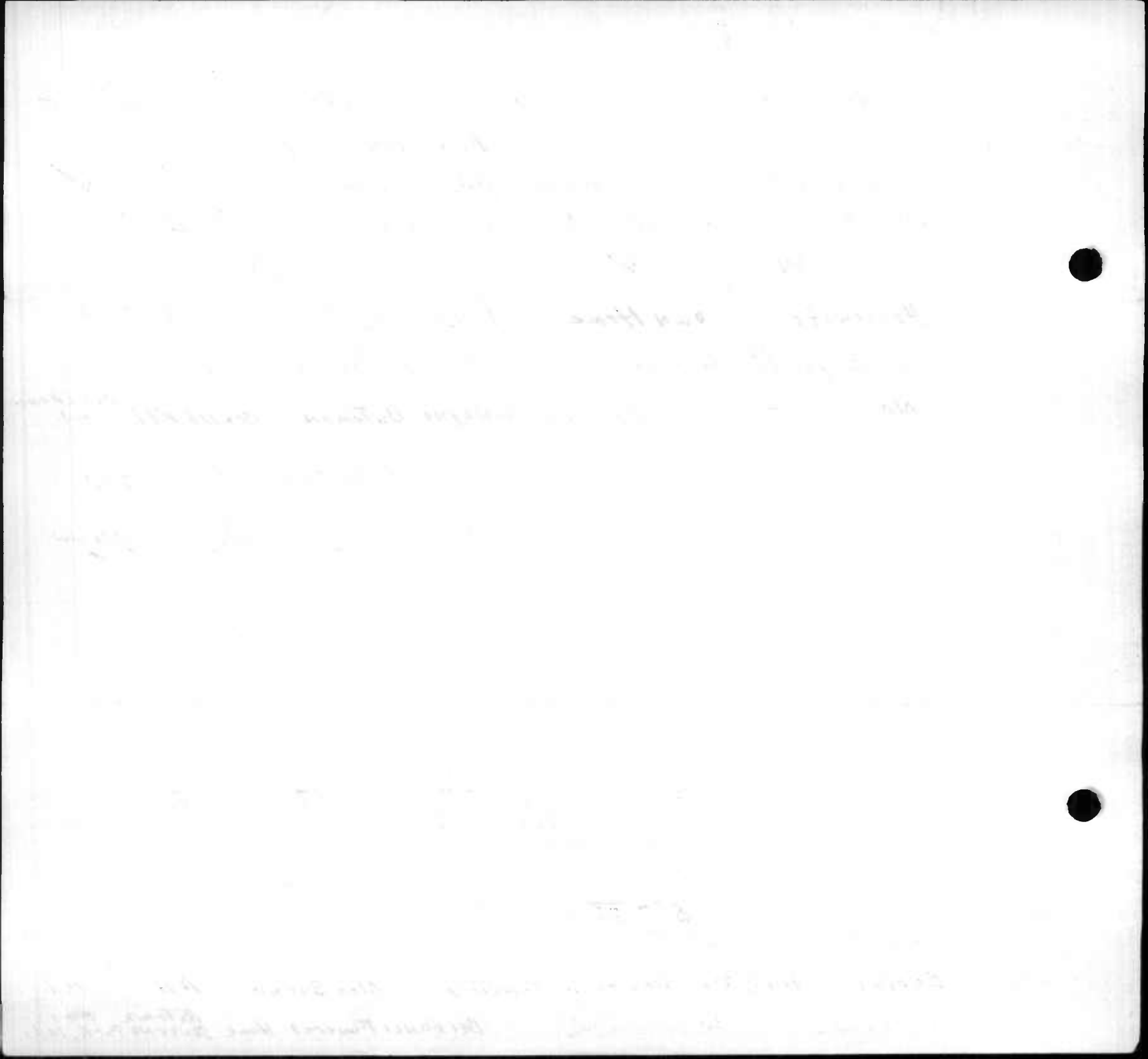
23rd Street, N.W., Wash. D.C.

British Light Brown
Bureau Co., Inc.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> R-530 72 06341 BALTIMORE CITY HEALTH DEPARTMENT 72 06341 </div>			
<div style="display: flex; justify-content: space-between;"> BIRTH NO. STATE OF MARYLAND-DHMH CERTIFICATE OF DEATH REG. NO. </div>			
1. NAME OF DECEASED (Type or Print) Roundy Maggie Annie		2. DATE AND HOUR OF DEATH 7/2/72 11:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bolton Hill Nursing Home Lafayette And John Street.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Box 116 RT. 9 B. COUNTY AA C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Pasadena, Maryland	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/181
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY OWN Home	9. AGE (In years last birthday) 90
11. BIRTHPLACE (State or foreign country) Ridgeway VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Bateman		14. MOTHER'S MAIDEN NAME MARY Hutchinson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 824-07-5652	
17. INFORMANT Wayne Bateman		ADDRESS Pasadena Md.	
18. 4/2-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) arteriosclerotic heart disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, arteriosclerotic generalized		(B) DUE TO, OR AS A CONSEQUENCE OF: years	
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/2 19 67 to 7/2 19 72 that (I) (we) last saw the deceased alive on 7/2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Allan Macht		23B. DATE SIGNED 7/4/72	
23C. PHYSICIAN'S NAME (Type) DR. ALLAN MACHT		23D. ADDRESS 647-8615	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5, 1972	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie AA Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Barbara K. K...	
25C. FUNERAL DIRECTOR Barbara K. K...		ADDRESS Ritchie Hwy Severna Park, Md.	



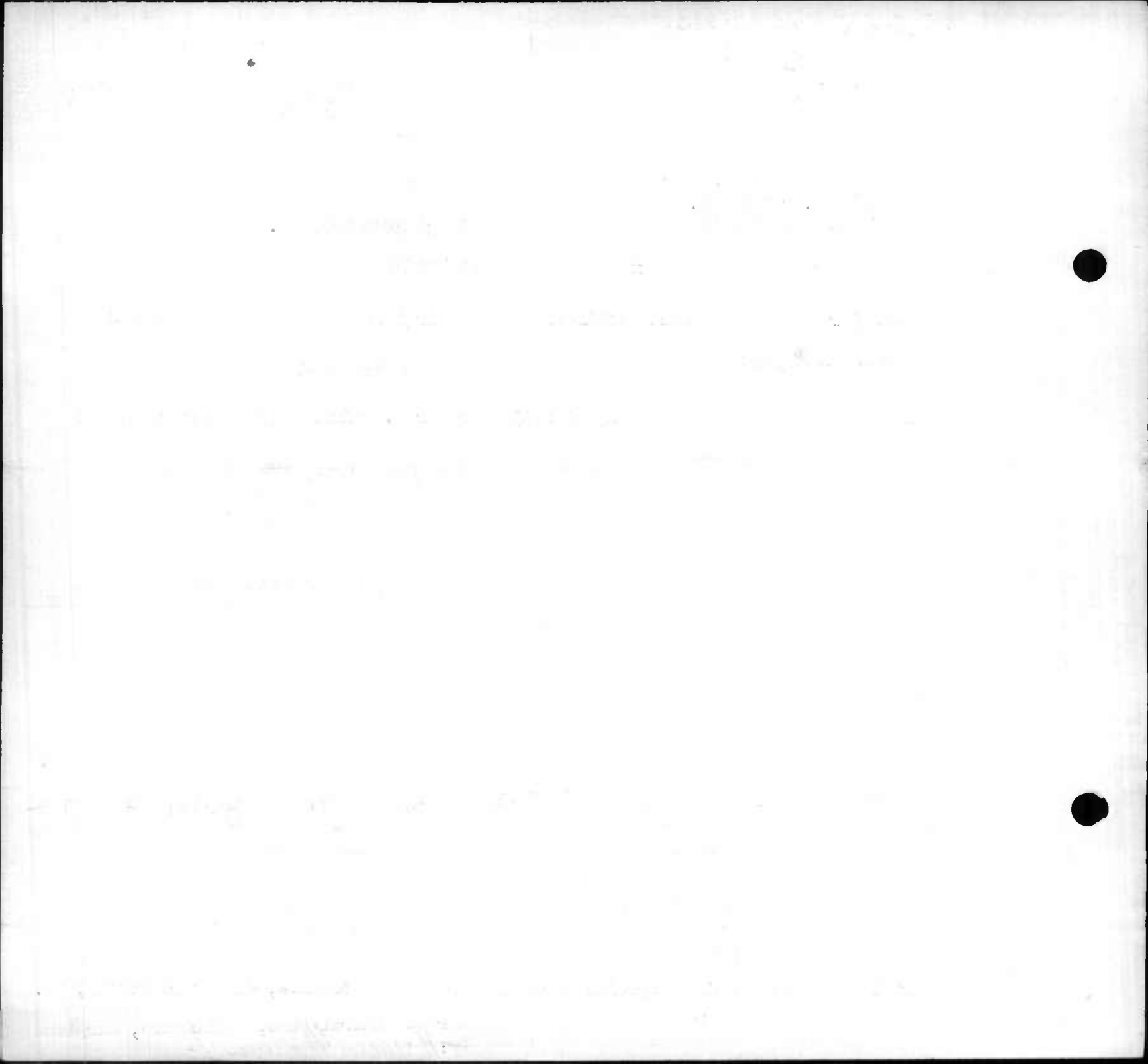
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06342		BALTIMORE CITY HEALTH DEPARTMENT	
W-614		CERTIFICATE OF DEATH	
BIRTH NO. STATE OF MARYLAND-DEMH		REG. NO. 72 06342	
1. NAME OF DECEASED (Type or Print) WROBLEWSKI, BOLESLAUS		2. DATE AND HOUR OF DEATH 7-3-72 1 5⁰⁰ AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL, BALTO, MD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 523 S. 45TH ST.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1896 04-22-93 9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Wieskettle Co	11. BIRTHPLACE (State or foreign country) POLAND
13. FATHER'S NAME JOSEPH WROBLEWSKI		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 213-01-5745	17. INFORMANT HOSPITAL RECORD ADDRESS
18. 162-1 I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA		2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CA OF LUNG 2 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION NONE	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-16-72 to 7-3-72 19____ that (I) (we) last saw the deceased alive on 7-3-72 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Bernard Yukwa		23B. DATE SIGNED 7-3-72	
23C. PHYSICIAN'S NAME (Type) BERNARD YUKWA		23D. ADDRESS CHURCH HOME & HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-6-72	24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR WALTER DABROWSKI	
		25C. FUNERAL DIRECTOR ADDRESS 1005 DUNDALK AVENUE	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>5-520 72 06343</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 06343</p>	
<p>BIRTH NO. STATE OF MARYLAND-DIME</p> <p>1. NAME OF DECEASED (Type or Print) Katie SH ANK</p>		<p>2. DATE AND HOUR OF DEATH July 2 1971 6⁰⁰ P M</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 CENTURY HOME, Inc 102 N. Poca St. Balto Md 21201</p>		<p>4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY 1306</p> <p>C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 3545 Keswick Rd.</p>	
<p>5. SEX F</p>	<p>6. RACE W</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 12/27/84</p>
<p>9. AGE (In years last birthday) 87</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier</p>	<p>11. BIRTHPLACE (State or foreign country) Virginia</p>
<p>12. CITIZEN OF WHAT COUNTRY? U S A</p>		<p>13. FATHER'S NAME Russell Figgins</p>	
<p>14. MOTHER'S MAIDEN NAME Henrietta Henry</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>	
<p>16. SOCIAL SECURITY NO. 219 62 2833</p>		<p>17. INFORMANT Arthur O. Haines ADDRESS 3356 Hickory Avenue</p>	
<p>18. 4/2-2 I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> <p>19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?</p> <p>22. I certify that (I) (this hospital) attended the deceased from Dec 30 1971 to July 2 1972 that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> <p>23A. SIGNATURE William D. Appleford DEGREE DEGREE 23B. DATE SIGNED</p> <p>23C. PHYSICIAN'S NAME (Type) William D. Appleford DEGREE DEGREE 23D. ADDRESS 6615 Rutherford Rd</p> <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 6 June 72 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery 24D. LOCATION (City, town, or county) (State) Woodlawn, Baltimore County, Md.</p> <p>25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972 25B. NAME OF REGISTRAR Edith J. Hinton 25C. FUNERAL DIRECTOR Burges Funeral Home, Baltimore, Maryland ADDRESS By: H. Grace W. Hinton</p>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) VOGT, BERNISE SAMUEL		2. DATE AND HOUR OF DEATH 07 05 72 9:35 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2005	
5. SEX MALE		6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCKMAN		10B. KIND OF BUSINESS OR INDUSTRY VENETIAN BLIND CO	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME SAMUEL VOGT		14. MOTHER'S MAIDEN NAME CLARA MANNA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 07 5095	17. INFORMANT ST AGNES HOSPITAL RECORDS CATON & WILKENS AVES BALTO MD 21229
18. 2005 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Cachexia due to malignancy DUE TO, OR AS A CONSEQUENCE OF: (C) Lymphosarcoma - Chronic lymphatic leukemia	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XIX (this hospital) attended the deceased from 06 19 19 72 to 07 05 19 72 , that XIX (we) last saw the deceased alive on 07 05 19 72 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.			
23A. SIGNATURE Eitatsu Henzan		23B. DATE SIGNED 7/5/72	
23C. PHYSICIAN'S NAME (Type) EITATSU HENZAN, M.D.		23D. ADDRESS ST AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/1972	
24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Anthony J. [Signature]	
25C. FUNERAL DIRECTOR G. Truman Schwab		ADDRESS 5151 Balto. Nat'l. Pike	

RECEIVED

DATE

TIME

TO

FROM

DATE

TIME

LOCATION

STATUS

REMARKS

REMARKS

THIS IS A SUMMARY OF THE INFORMATION RECEIVED FROM THE FIELD OFFICES ON THE DATE OF THE REPORT.

DATE

TIME

DATE

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DATE

TIME

THIS IS A SUMMARY OF THE INFORMATION RECEIVED FROM THE FIELD OFFICES ON THE DATE OF THE REPORT.

REMARKS

REMARKS

REMARKS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460		72 06345		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06345	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) <u>Mrs. Samuel Taylor</u>				2. DATE AND HOUR OF DEATH <u>7/4/72</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2757</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSPITAL</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>		6. RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/97</u>	
9. AGE (In years last birthday) <u>75</u>		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Black & Decker</u>		11. BIRTH PLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>SAMUEL M. TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>EVA WEST</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. 1</u>				16. SOCIAL SECURITY NO. <u>213-10-5503</u>		17. INFORMANT <u>MRS Jessie Taylor</u>	
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>GENERALIZED ARTERIOSCLEROSIS</u> <u>DIABETES MELLITUS</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CHRONIC CEREBRAL SYNDROME</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) [Month] [Day] [Year] [Hour]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 3</u> 19 <u>72</u> to <u>July 4</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>July 4</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Kenan A. Dieppa</u> SMS DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>July 4/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>KENAN A. DIEPPA</u> SMS DEGREE				23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/7/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>		25B. NAME OF REGISTRAR <u>Dwight Johnson</u>		25C. FUNERAL DIRECTOR <u>Robert C. Altenburg Funeral Home, Inc.</u> 6009 Harford Road Balto., Md. 21214			

FUNERAL DIRECTOR: IMPORTANT

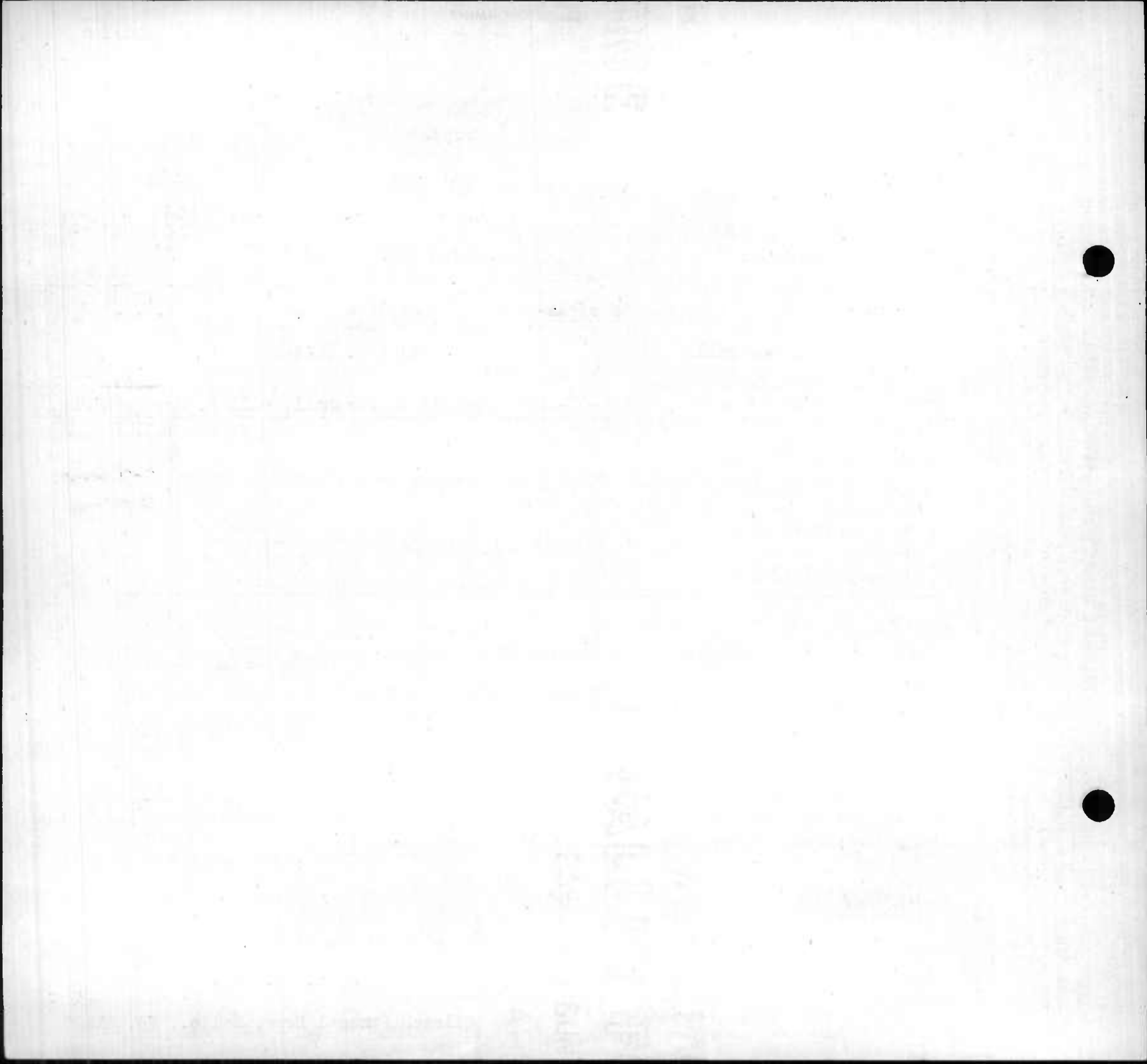
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-243</u> <u>72 06346</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 06346</u>	
1. NAME OF DECEASED (Type or Print) <u>Dewey L. McLeod</u>				2. DATE AND HOUR OF DEATH <u>7.5.72</u> <u>1145 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hosp. & 37 Balto md 21202</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>Maryland</u>		B. COUNTY <u>901</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>517 E 38th St 21218</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/1900</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Daniel McLeod</u>				14. MOTHER'S MAIDEN NAME <u>Martha Bate</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-0826A</u>		17. INFORMANT ADDRESS <u>Mrs. Doris M. Stanley-6912 Chambers Rd</u>			
18. <u>430X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Multiple Pulmonary embolisms</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 to 20 min</u>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Exact source of above not discovered.</u>			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>6-30-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Internal Org. Hernias</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCURRED			
22. I certify that (1) (this hospital) attended the deceased from <u>6-27</u> 19 <u>72</u> to <u>7-5</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>7-5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Leonard J. Hamberry M.D.</u> DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7.5.72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Leonard Hamberry, M.D.</u> DEGREE				23D. ADDRESS <u>323-25 Medical Arts Bldg Balto md 21201</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>7/8/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Neals Creek Baptist Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Lillington, North Carolina</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>		25B. NAME OF REGISTRAR <u>Anthony Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. - Balto., Md. 21214</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

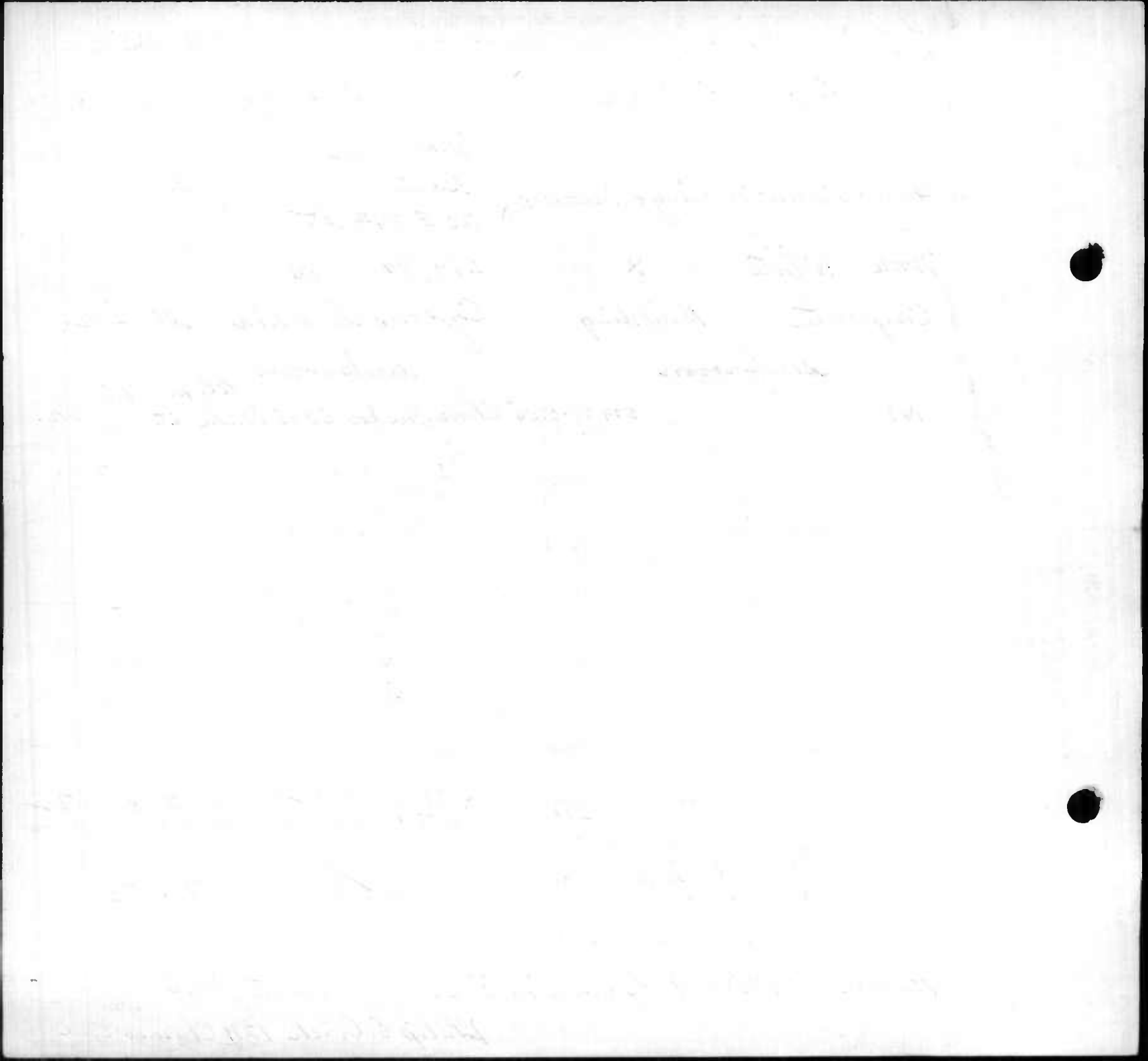
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06347	
BIRTH NO. 72 06347				STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
THOMAS WILLIAM MARSHALL			5 July, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
3204 Montebello Terrace. 21214			Maryland		
5. SEX			6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male			Caucasian		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH			9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
30 Jan 1892			80		executive
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME
Maryland			U.S.A.		Louis W. Marshall
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
Caroline M. Weilert			yes WW I		
16. SOCIAL SECURITY NO.			17. INFORMANT		
216-01-3846			Russell S. Marshall, 4110 E. Northern Pky.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			C.H.F.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Chronic heart disease 6 yrs.		
II			(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Chicken pox		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
0			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			22. I certify that (I) (this hospital) attended the deceased from 1968 to 7/5/72, that (I) (we) last saw the deceased alive on 7/2/72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE			23B. DATE SIGNED		
W. Karfgen, MD			7/7/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
W. Karfgen, MD			4331 Harford Rd. 21214		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
burial			8 July 72		
24C. NAME OF CEMETERY OR CREMATORY			24D. LOCATION (City, town, or county) (State)		
Parkwood Cemetery			Balto. Co., Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
JUN 10 1972			Sidney Whorton		
25C. FUNERAL DIRECTOR			ADDRESS		
Ulrich Funeral Home, Balto., Md. 21206					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

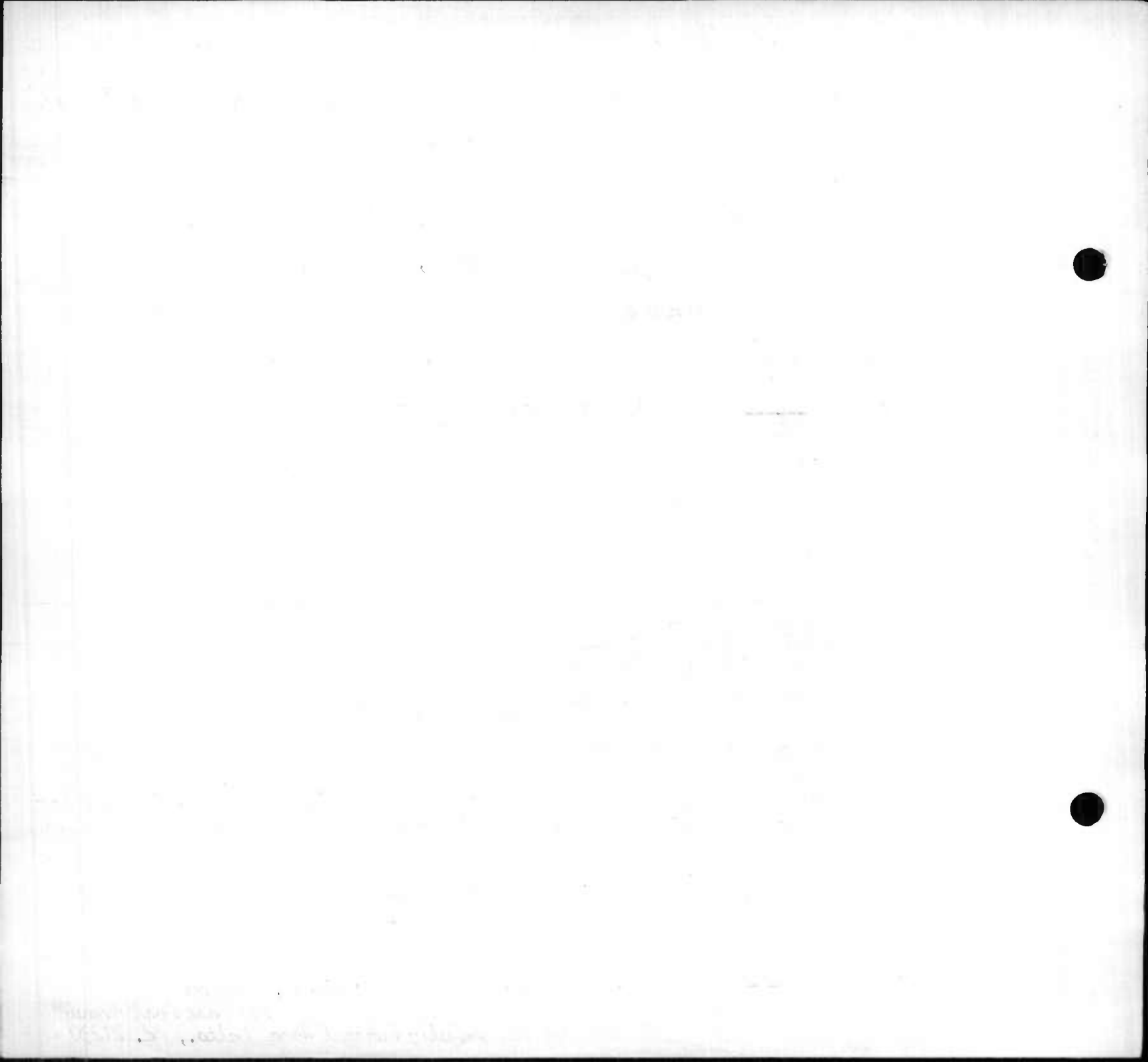
BIRTH NO. <i>P-200</i>		72 06348		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06348	
1. NAME OF DECEASED (Type or Print) <i>Godfrey B. Paska</i>				2. DATE AND HOUR OF DEATH <i>7-4-72</i> <i>2:00 P</i> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Harbor View nursing + Convalescent</i>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1206</i>		C. CITY OR TOWN <i>Balto.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>90</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>20 E 24th St</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/9/86</i>	9. AGE (in years last birthday) <i>86</i>	If Under 1 Yr. Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Building</i>		11. BIRTHPLACE (State or foreign country) <i>Czechoslovakia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>579-07-0754</i>				17. INFORMANT <i>Char. Paska</i> ADDRESS <i>Alexandria Va.</i>					
18. <i>185X I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>CA. of prostate c</i> <i>Metastases</i> <i>A.S.C.V.D.</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7/3</i> 19 <i>72</i> to <i>7/3</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>7/3</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Joseph S. Blum</i>				23B. DATE SIGNED <i>7/5/72</i>		23C. PHYSICIAN'S NAME (Type) <i>JOSEPH S. BLUM MD</i>		23D. ADDRESS <i>1115 N CALVERT ST</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/7/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Bohemian National</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 10 1972</i>				25B. NAME OF REGISTRAR <i>Andrew Whitton</i>		25C. FUNERAL DIRECTOR <i>Philip E. Croach</i>		ADDRESS <i>1211 Chesaco Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>8-530 72 06349</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p>	
<p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 06349 STATE OF MARYLAND-DEATH</p>	
<p>BIRTH NO. 1. NAME OF DECEASED (Type or Print) SMITH, ANNA</p>		<p>2. DATE AND HOUR OF DEATH July 6-72 6:45 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2302</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HARBOR View Nursing Home 1210 Light St.</p>		<p>C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>5. SEX F</p>		<p>6. RACE W</p>	
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH May 13, 1878</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY At home</p>	
<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Andrew Anderson</p>		<p>14. MOTHER'S MAIDEN NAME Francis Johnson</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p>16. SOCIAL SECURITY NO. 21658 20859</p>	
<p>17. INFORMANT Chart</p>		<p>ADDRESS</p>	
<p>18. CAUSE OF DEATH</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Terminal Bilat. Pneumonia</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Terminal Bilat. Pneumonia 5 days</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) A.S. C.V.D. (C) Chronic Decompensation 2 weeks</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chr. Sr. Damage</p>		<p>?</p>	
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> 19 <u>70</u> to <u>7/5</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Jos. S. Blum</p>		<p>23B. DATE SIGNED 7/7/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) Jos. S. Blum MD</p>		<p>23D. ADDRESS 1115 N CALVERT ST</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 7-8-72</p>	
<p>24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972</p>		<p>25B. NAME OF REGISTRAR Anthony Johnson</p>	
<p>25C. FUNERAL DIRECTOR McGully Funeral Home Balto., Md. 21230</p>		<p>ADDRESS 130 East Fort Avenue</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>S-421-72 06350</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 06350</p>	
<p>BIRTH NO. STATE OF MARYLAND-DEMH</p>		<p>1. NAME OF DECEASED (Type or Print) Schlossberg, Joseph</p>	
<p>2. DATE AND HOUR OF DEATH 7-6-72 9:40 p.m.</p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 Mercy Hospital</p>	
<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1510</p>		<p>5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH XXXXXX 1890 9. AGE (In years last birthday) 82 10. BIRTHPLACE (State or foreign country) LITHUANIA</p>		<p>11. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>12. CITY OR TOWN Baltimore 13. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>		<p>14. STREET AND NUMBER 4201 Granada Av. 21215</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I</p>		<p>16. SOCIAL SECURITY NO. 322-03-1898A 17. INFORMANT MRS. SARAH COHEN, 7111 PK. HGHTS. AVE., APT. 202</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Arrest</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes, Arteriosclerosis obliterans with gangrene. Arteriosclerotic heart failure. Renal insufficiency.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p>		<p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 05-9-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED transurethral resection</p>		<p>20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 4/5/72 19 to 7/6/72 19 that (I) (we) last saw the deceased alive on 7/6/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>		<p>23A. SIGNATURE 23B. DATE SIGNED 7/6/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) William Davidson 23D. ADDRESS</p>		<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 7/7/72 24C. NAME OF CEMETERY or CREMATORY BETH TFILOH 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972 25B. NAME OF REGISTRAR SOL LEVINSON 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</p>		<p>ADDRESS</p>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	72 06351
7-215 72 06351		STATE OF MARYLAND-DEME		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Hyman Fishbone		2. DATE AND HOUR OF DEATH 7/6/72 10³⁰ P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 91 Levindale Hebrew Geriatric Center Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7938 DUNHILL VILLAGE CIRCLE, #21207			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/1885	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY GROCEER		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BERISH FISHBONE			
14. MOTHER'S MAIDEN NAME BELLA ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT MR. IRVIN FISHBONE, 3650 PASKIN PL. APT. 2 A			
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Coronary disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic heart disease with heart failure Pneumonia Urinary tract infection		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days many years 2 days years			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-8 19 72 to 7-6 19 72 , that (I) (we) last saw the deceased alive on 7-6 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Soonchul Hong, M.D.				23B. DATE SIGNED 7-6-1972	
23C. PHYSICIAN'S NAME (Type) SOONCHUL HONG				23D. ADDRESS ROSEDALE, MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/7/72		24C. NAME OF CEMETERY or CREMATORY FORBAND	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972			
25B. NAME OF REGISTRAR Andrey K. Koston		25C. FUNERAL DIRECTOR Sal Levinson Bros.			
25D. ADDRESS 6010 REISTERSTOWN RD.					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		STATE OF MARYLAND - DEPT. OF HEALTH		BALTIMORE CITY HEALTH DEPARTMENT		72 06352		72 06352	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				REG. NO.	
Gordon, Sophia				July 5, 1972				8:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				B. COUNTY Baltimore				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				2720	
E. STREET AND NUMBER 3700 Kingwood Square 21215									
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 28, 1909	9. AGE (in years last birthday) 62	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours	13. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY AT HOME				11. BIRTHPLACE (State or foreign country) BROOKLYN, New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Nathan ROSENBERG				14. MOTHER'S MAIDEN NAME Anna ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.				17. INFORMANT MR. WILLIAM GORDON 3700 KINGWOOD SQUARE #21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary - pulmonary Failure DUE TO, OR AS A CONSEQUENCE OF: (B) acute intercranial hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (C) acute myelogenous Leukemia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs. 4-5 hrs. 3-5 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/3/1972 to 7/5/1972 that (I) (we) last saw the deceased alive on 7/5/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ronald G. Banks M.D.				23B. DATE SIGNED 7/5/72					
23C. PHYSICIAN'S NAME (Type) RONALD G. BANKS M.D.				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland Baltimore City Hospitals 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 7/6/72				24C. NAME OF CEMETERY or CREMATORY SHAAREI TFILOH	
24D. LOCATION BALTIMORE, MARYLAND									
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972				25B. NAME OF REGISTRAR Sol Levinson				25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 06353	
G-635-72 06353				72 06353	
STATE OF MARYLAND - DHMH				REG. NO. _____	
BIRTH NO. _____				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		ANNE GRODNITZKY		2. DATE AND HOUR OF DEATH 7/6/72 9:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY _____		2740	
FULL NAME OF HOSPITAL OR INSTITUTION 33		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION JOHNS HOPKINS HOSPITAL 601 N. BROADWAY		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3126 PARKINGTON AVENUE APARTMENT C	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/19	9. AGE (In years last birthday) 53	10. Under 1 Yr. Months: Days: Hours: Min. 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORRIS KIRSCH		14. MOTHER'S MAIDEN NAME SADIE CARMEL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 578 09 9923		17. INFORMANT MR. ISADLORE GRODNITZKY, 3126 PARKINGTON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 174X I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ANTECEDENT CAUSES II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardio-renal arrest DUE TO, OR AS A CONSEQUENCE OF: (B) metastatic ca of breast DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
19A. DATE OF OPERATION 03/61		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ca of breast		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 1922 that (I) (we) last saw the deceased alive on _____ 7/6/1922 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael R. Petrcek, MD		23B. DATE SIGNED 7/6/72			
23C. PHYSICIAN'S NAME (Type) MICHAEL R. PETRACEK, MD		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/7/72		24C. NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Andrew Whorton		25C. FUNERAL DIRECTOR Salvatore Beas	
				ADDRESS 6010 REISTERSTOWN RD	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06354
BIRTH NO. STATE OF MARYLAND - DHMH		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) DORA BRAVERMAN		2. DATE AND HOUR OF DEATH JULY 5, 1972 1:20 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BELVEDERE NURSING HOME		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2916 WOODLAND AVENUE #21215		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 18, 1894	9. AGE (In years lost birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA
13. FATHER'S NAME ? TRETRICH		14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-36-1621		17. INFORMANT ADDRESS MRS. IDA PALTELL, 2916 WOODLAND AVE. #21215
CAUSE OF DEATH				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral ischemia & respiratory hypoxia (B) DUE TO, OR AS A CONSEQUENCE OF: Central atherosclerosis & senile changes (C) ASCVD		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Decubitus ulcers (multiple)				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3-15 1968 to 7-5 1972, that (I) (we) last saw the deceased alive on 6-15-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE H. Gerald Oster MD				23B. DATE SIGNED 7-6-72
23C. PHYSICIAN'S NAME (Type) H. GERALD OSTER		23D. ADDRESS 6821 REISTERS TOWN ROAD		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/6/72		24C. NAME OF CEMETERY or CREMATORY WORKMENS CIRCLE
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		
25B. NAME OF REGISTRAR Sol Levinson		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 06355		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06355
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
JONES, JOHN TAYLOR		JULY 4, 1972 10:10 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		A. STATE MARYLAND		
		B. COUNTY 2864		
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01/17/98
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 74
Die Setter		Revere Copper & Brass Inc.		If Under 1 Yr. Months: Days: Hours: Min.
13. FATHER'S NAME JOHN T. JONES		14. MOTHER'S MAIDEN NAME NELLIE DE FORD		12. CITIZEN OF WHAT COUNTRY? U S A
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216109862		17. INFORMANT CATION AVES., BALTO., MD. 21229 ST AGNES HOSPITAL RECORDS, WILKENS &
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE C.V.A. DUE TO, OR AS A CONSEQUENCE OF: (B) a.s.c.v.d. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 days years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from JUNE 28, 19 72 to JULY 4, 19 72, that (1) (we) lost saw the deceased alive on JULY 4, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE J.J. Mal		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) J.J. Mal
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/1972		24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		
25B. NAME OF REGISTRAR G. Truman Schwab		25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave.		

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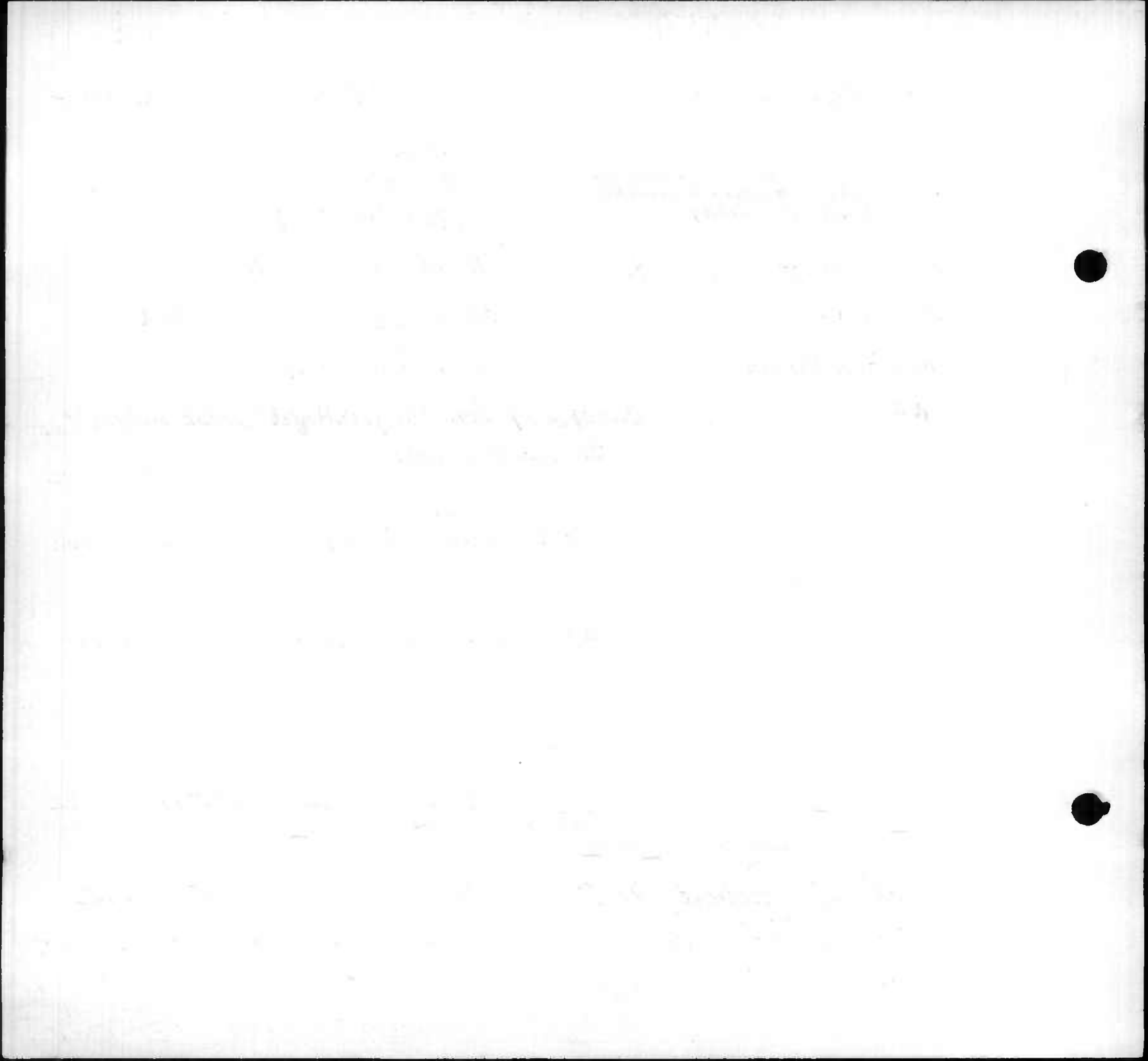
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> R-200 72 06356 BALTIMORE CITY HEALTH DEPARTMENT </div>		<div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH 72 06356 </div>	
BIRTH NO. STATE OF MARYLAND-DEMD 1. NAME OF DECEASED (Type or Print) Mary E. Ross		2. DATE AND HOUR OF DEATH 5 July 72 12:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BOULEVARD BALTO., MD. 21239		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1808 Elk Road	
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-81
9. AGE (In years last birthday) 90		10. Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin Myers		14. MOTHER'S MAIDEN NAME Rose Eccleston	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 220-013879	
17. INFORMANT Son - George D. Hays		ADDRESS 2830 E. Madison St	
18. 4339 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihemia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 June 1972	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: unknown (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic Heart Disease			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-20 1972 to 5 July 1972 that (I) (we) lost saw the deceased alive on 5 July 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John D. Talbert, MD		23B. DATE SIGNED 5 July 72	
23C. PHYSICIAN'S NAME (Type) John D. Talbert MD		23D. ADDRESS 5601 Loch Raven Blvd. Balto. Md 21239	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/8/72	
24C. NAME OF CEMETERY or CREMATORY MORELAND		24D. LOCATION (City, town, or county) (State) BALTO. M.D.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR George D. Hays	
25C. FUNERAL DIRECTOR George D. Hays		ADDRESS 301	



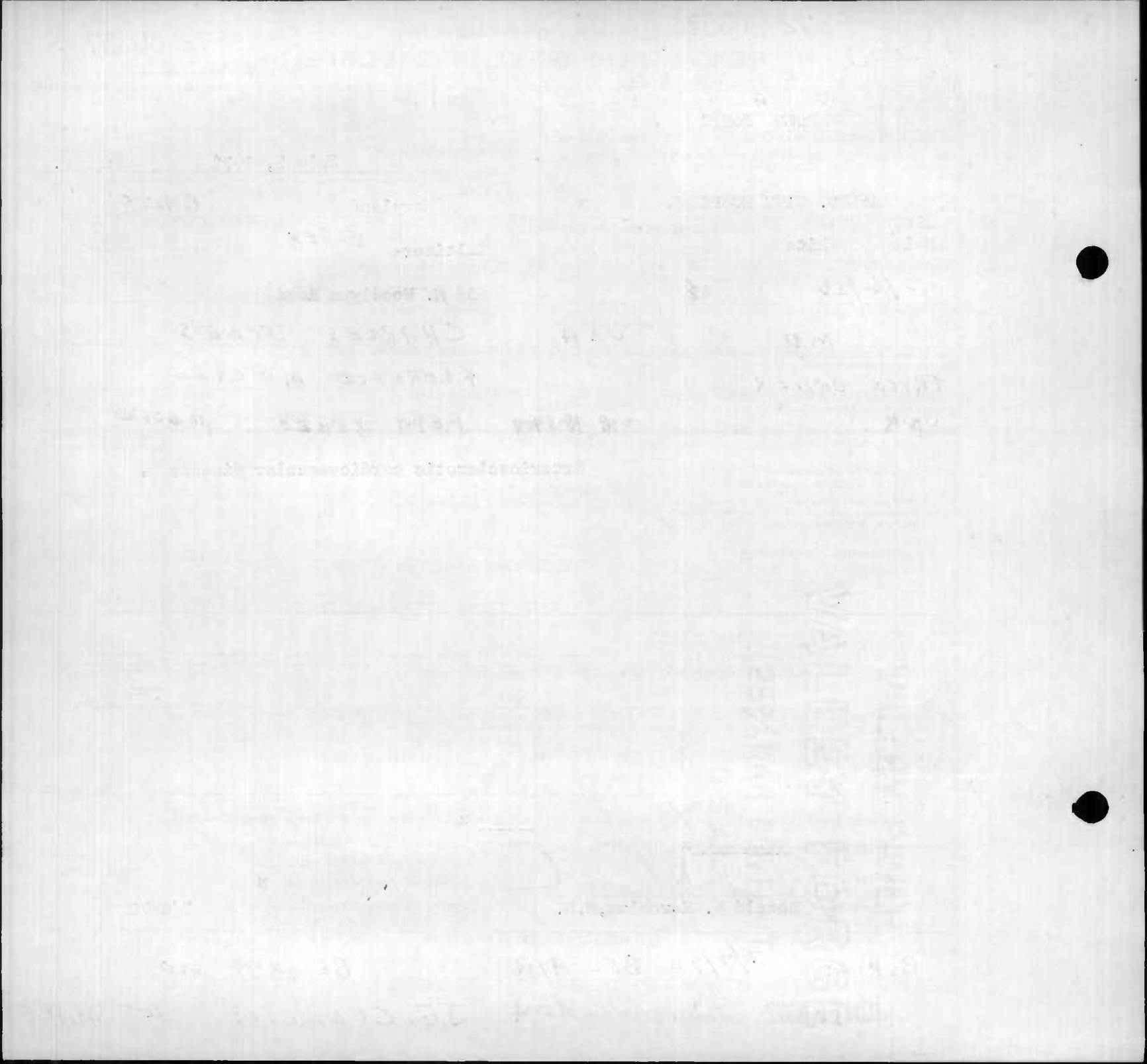
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

STATE OF MARYLAND-DEMR

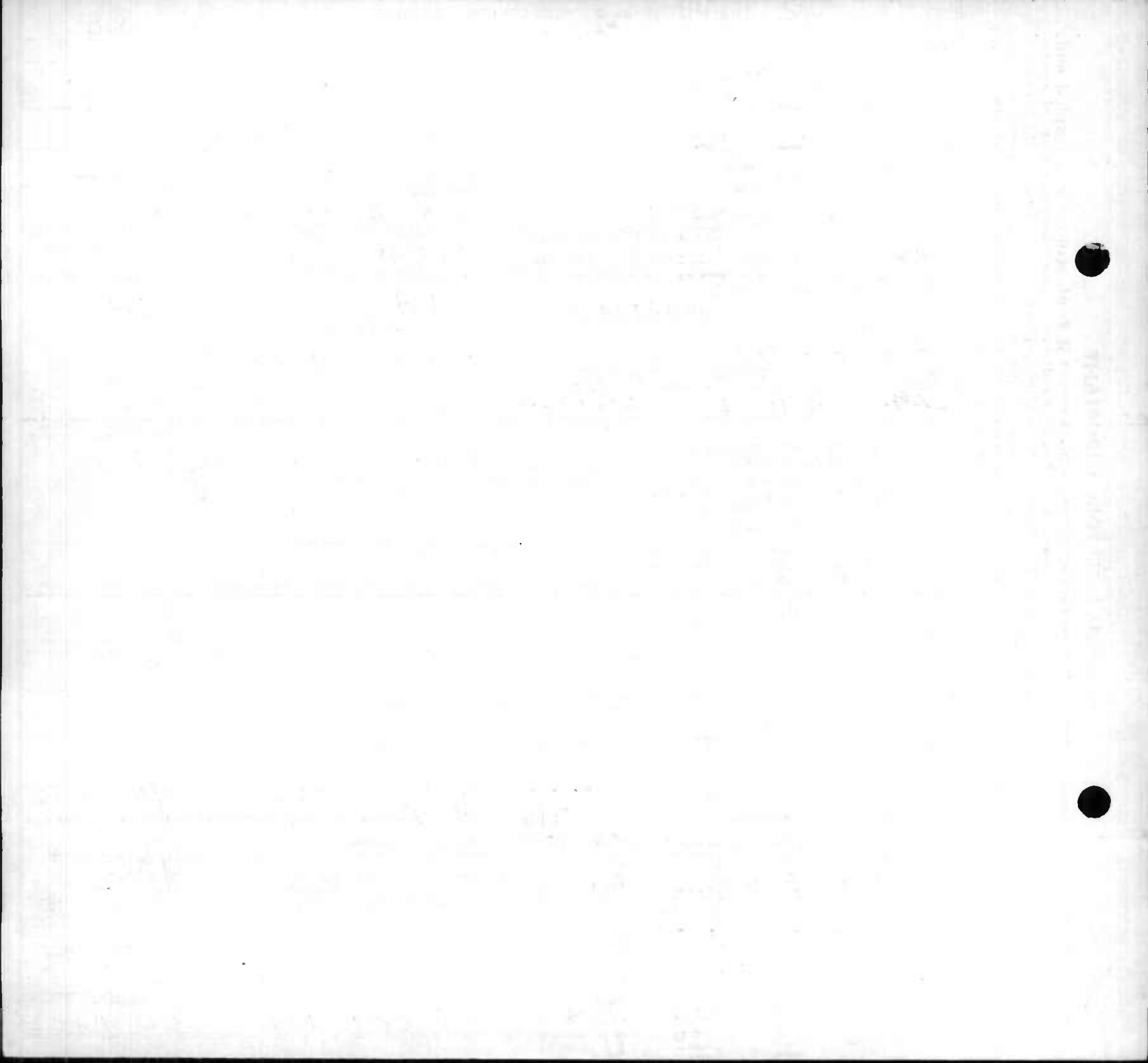
REG. NO.

1. NAME OF DECEASED (Type or Print) A. HAROLD JONES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTO. CITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour July 3, 1972 8:50 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore ESSEX	
9. DATE OF BIRTH 2/6/26		10. AGE (In years lost birthday) 46	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME FLORENCE McANN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNK	
17. SOCIAL SECURITY NO. 218-18-5909		18. INFORMANT REBA JONES	
19. 412-4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/4/72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/7/72	
24C. NAME of CEMETERY or CREMATORY BEL AIR		24D. LOCATION (City, town, or county) (State) BEL AIR MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Aisley Whorton	
25C. FUNERAL DIRECTOR J.G. CONNELLY		ADDRESS 300 MACE	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

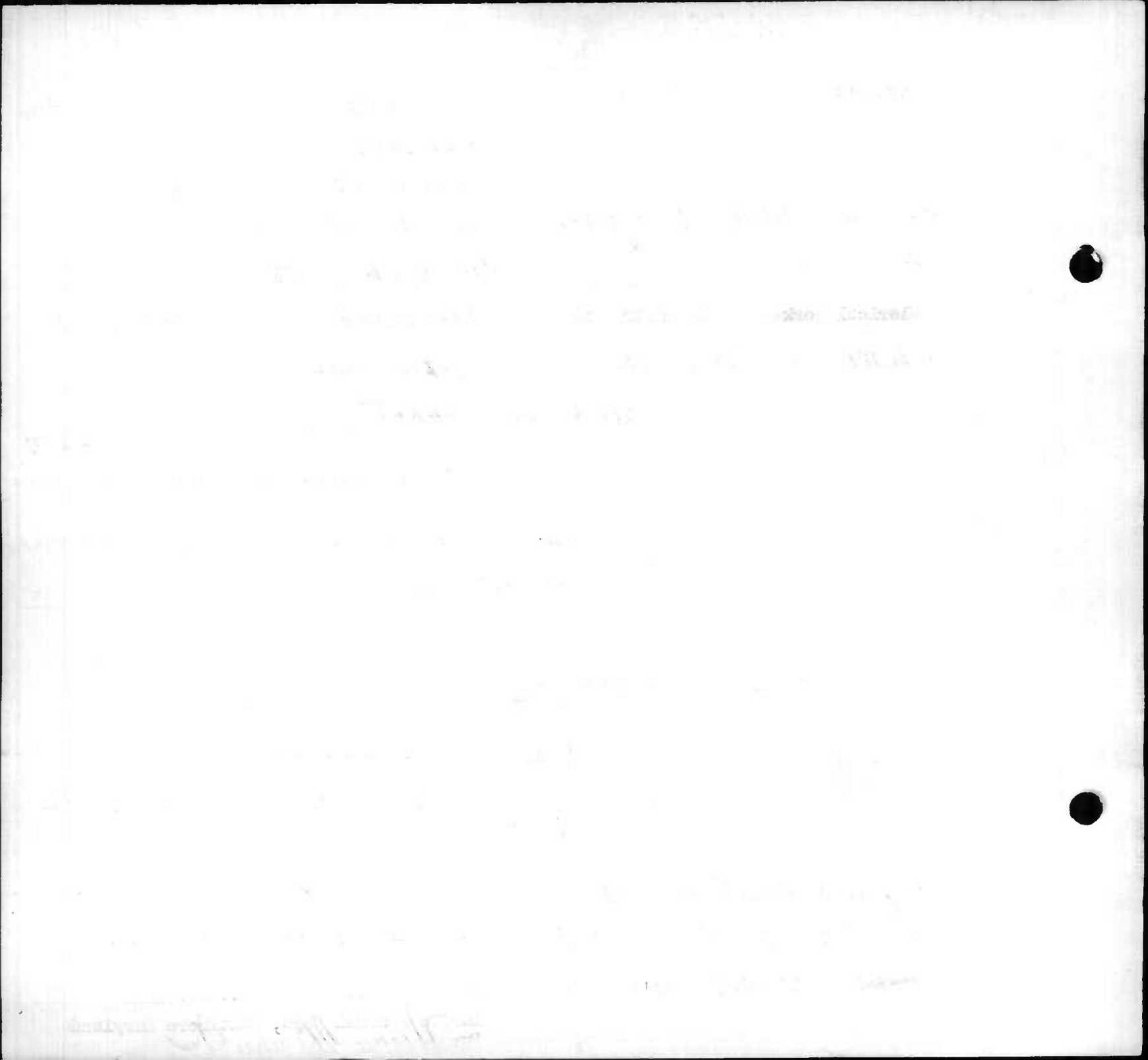
B. 415 72 06358		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06358	
BIRTH NO. STATE OF MARYLAND-DEME		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) William Blevins		2. DATE AND HOUR OF DEATH July 6, 1972		1:19 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO		5. CITY OR TOWN SPARROWS PT.	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 2508 N. SYNDER AVE	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7/98	9. AGE (In years lost birthday) 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY MARTINS		11. BIRTHPLACE (State or foreign country) VA.	
13. FATHER'S NAME ELI BLEVINS		14. MOTHER'S MAIDEN NAME ANNIE SANDERS		12. CITIZEN OF WHAT COUNTRY USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) JACK W W T		16. SOCIAL SECURITY NO. 228-03-6465		17. INFORMANT BCH: RECORDS 4940 Eastern Avenue Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the lung (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/6/72 to 7/6/72 that (I) (we) last saw the deceased alive on 7/6/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Steven R Kanner MD		23B. DATE SIGNED 7/6/72		23C. PHYSICIAN'S NAME (Type) Steven R. Kanner, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 7/8/72		24C. NAME OF CEMETERY or CREMATORY GALAX	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR J.G. CONNELLY		25C. FUNERAL DIRECTOR 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-660 72 06359		BALTIMORE CITY HEALTH DEPARTMENT		72 06359	
BIRTH NO. STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) NORMA V. BREWER			2. DATE AND HOUR OF DEATH July 6, 1972 2:00 p. m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2714 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 219 ALPINE RD		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1914	9. AGE (In years last birthday) 58	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Work			10B. KIND OF BUSINESS OR INDUSTRY Chemistry Lab		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? AMERICAN		
13. FATHER'S NAME WALTER G SCHAEFER			14. MOTHER'S MAIDEN NAME BAZIE BELL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212 30 0260		17. INFORMANT CHARI
18. 183.0 I CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE ACUTE MYOCARDIAL INFARCTION - 20 min DUE TO, OR AS A CONSEQUENCE OF: (B) CARCINOMA OF OVARY with metastasis - 1 mm DUE TO, OR AS A CONSEQUENCE OF: (C) HYPERTENSION		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION July 3, 1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ASCITIS, ADD mass prob ovarian		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 26, 1972 to July 6, 1972 that (I) (we) last saw the deceased alive on July 6, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mary R. Cristofani, M.D.			23B. DATE SIGNED July 6, 1972		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Dr. Isadore Scher, M.D.			23D. ADDRESS CHURCH HOME & HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10 Jul 72		24C. NAME OF CEMETERY or CREMATORY May's Chapel Cemetery	
24D. LOCATION Baltimore Co., Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Didi...		25C. FUNERAL DIRECTOR Burgee Funeral Home, Baltimore Maryland	



B-650

72 06360

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06360

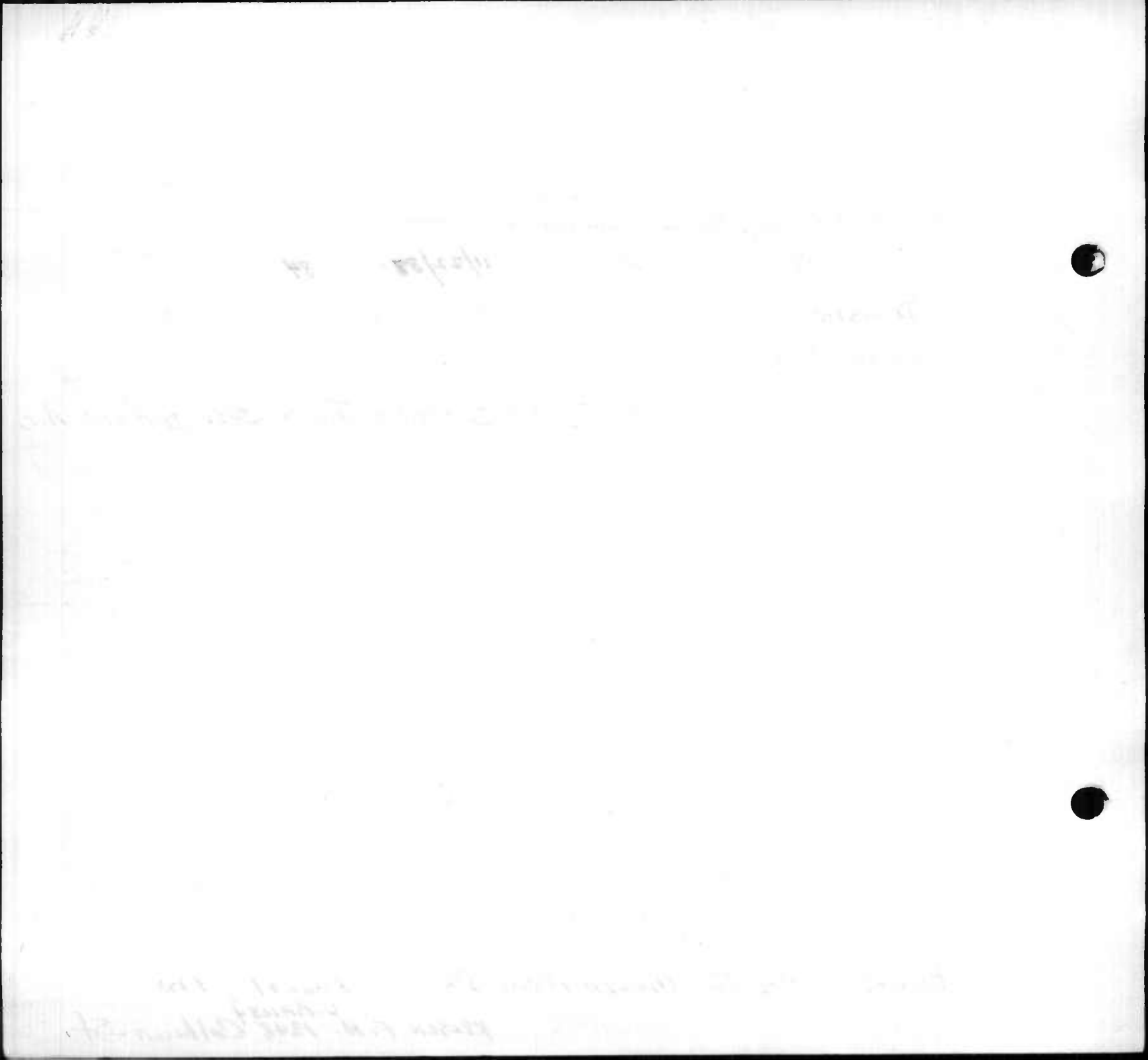
BIRTH NO. <u>STATE OF MARYLAND-DHMH</u>		REG. NO. _____	
1. NAME OF DECEASED (Type or Print) <u>George R. Brown Jr.</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <u>7 7 72 8:30 A. M.</u>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital</u>		3. DATE PRONOUNCED DEAD Month Day Year Hour <u>7 7 72 8:30 A. M.</u>	
6. SEX <u>Male</u>		7. RACE <u>Negro</u>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1537</u>	
9. DATE OF BIRTH <u>8-24-39</u>		10. AGE (In years last birthday) <u>32</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bethlehem Steel</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>Edith Gresham</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes 2-10-61/9-25-62</u>		17. SOCIAL SECURITY NO. <u>217349871</u>	
18. INFORMANT <u>Harriett Brown</u>		ADDRESS <u>same</u>	
19. <u>E966X 1</u>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Stabwound of chest</u> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Sidewalk</u>	
22D. TIME OF INJURY (APPROX.) <u>7 7 72 A.M.</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>in front of 3211 Gwynns Falls Parkway</u>		22F. HOW DID INJURY OCCUR? <u>Stabbed during altercation</u>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) <u>Yes</u>	
ACTUAL SIGNATURE <u>W P Mulloy</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William P. Mulloy, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-12-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>		25B. NAME OF REGISTRAR <u>W P Mulloy</u>	
25C. FUNERAL DIRECTOR <u>V. Bailey</u>		ADDRESS <u>Kelson F.H. 1348 Calhoun Street</u>	

ALG/ADP/16/17/18/19/20/21/22/23/24/25/26/27/28/29/30/31/32/33/34/35/36/37/38/39/40/41/42/43/44/45/46/47/48/49/50/51/52/53/54/55/56/57/58/59/60/61/62/63/64/65/66/67/68/69/70/71/72/73/74/75/76/77/78/79/80/81/82/83/84/85/86/87/88/89/90/91/92/93/94/95/96/97/98/99/100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-450 72 Q6361		BALTIMORE CITY HEALTH DEPARTMENT	
STATE OF MARYLAND-DEPT		CERTIFICATE OF DEATH	
BIRTH NO. 72 Q6361		REG. NO. 72 Q6361	
1. NAME OF DECEASED (Type or Print) <u>Falline Estelle</u>		2. DATE AND HOUR OF DEATH <u>7/1/72 8:35 pm</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Lafayette Ave. Bolton Hill Nursing Home John Street</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Dorchester</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Baltimore Maryland</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/22/87</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>84</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hiram Rusk</u>		14. MOTHER'S MAIDEN NAME <u>Eliza</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>818-22-7481</u>	
17. INFORMANT <u>ELIZABETH JONES</u>		ADDRESS <u>3456 Doffield Ave</u>	
18. <u>4124 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Terminal Broncho Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A.S.C.V. Disease</u>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Hypertension</u>	
		(C) <u>Ch. Brain Syndrome</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/24</u> 19 <u>72</u> to <u>6/29/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6/29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE <u>Dr. Joseph Blum</u>		23B. DATE SIGNED <u>7/7/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Joseph Blum</u>		23D. ADDRESS <u>1105 N. Calvert St</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-6-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Carver Mem. Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>		25B. NAME OF REGISTRAR <u>Lidney Whorton</u>	
25C. FUNERAL DIRECTOR <u>U. BAILEY</u>		ADDRESS <u>REIDSON F.W. 1348 Calhoun St.</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEROY QUARLES

2. DATE
OF DEATHKnown ☐ Month Day Year Hour
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4819 Norwood Avenue

3. DATE
PRONOUNCED DEAD

July 4, 1972

11:07 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9-19-28

10. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

4819 Norwood Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Nathaniel Williams

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Self-employed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Marie Quarles

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

Ella Quarles-wife

ADDRESS

same

19. E965X1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Gunshot wound of chest

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

4819 Norwood Avenue

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

7-4-72

10:45 P.M.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot during altercation

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/5/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-10-72

24C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 10 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR V. Bailey ADDRESS

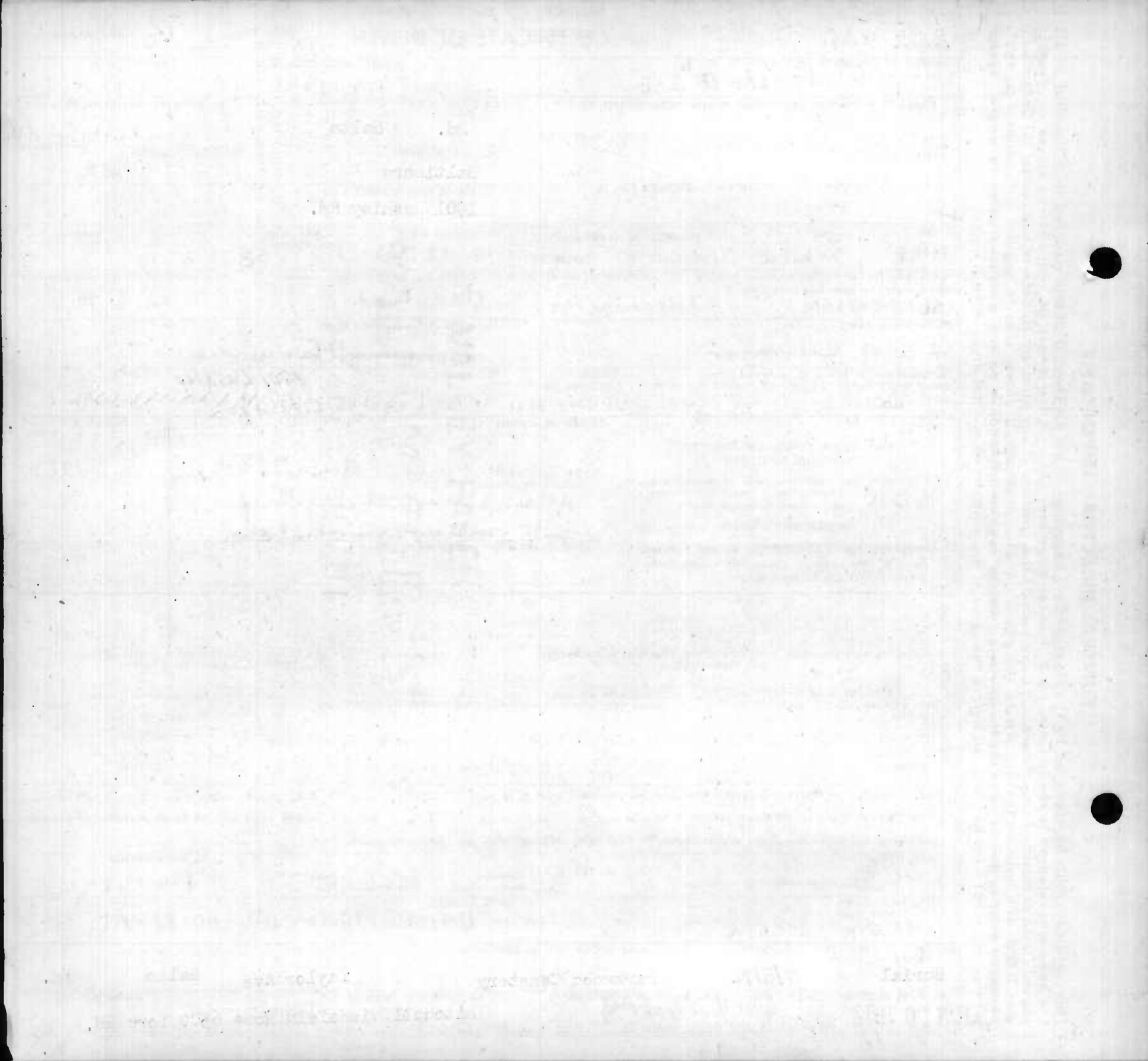
Kelson F.H. 1348 Calhoun Street

MAIL LETTER BOX

FUNERAL DIRECTOR: IMPORTANT

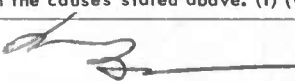
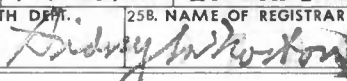
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

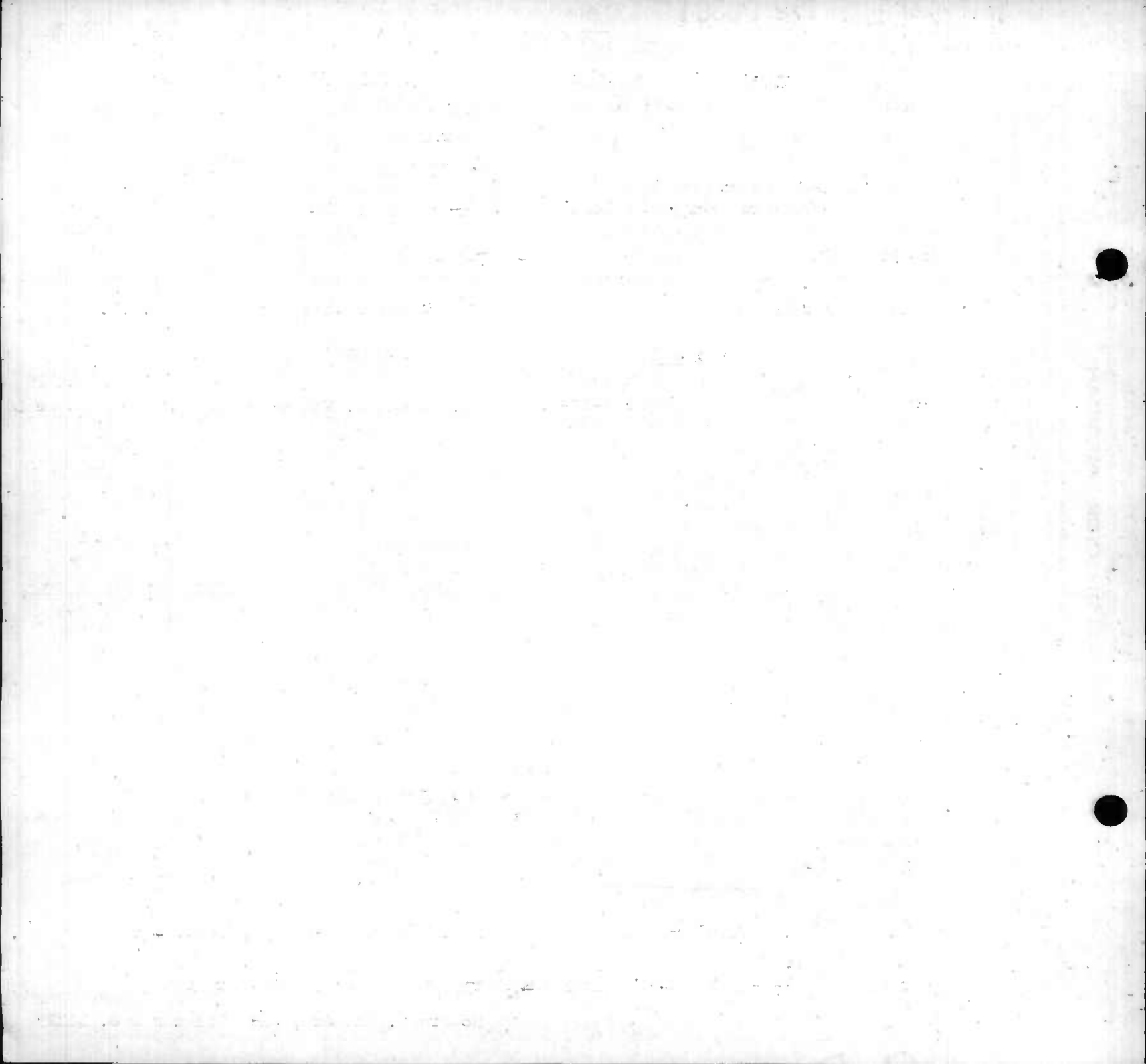
BIRTH NO. <u>L-325</u> <u>72 06363</u> <u>STATE OF MARYLAND-DHMH</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>72 06363</u>	
1. NAME OF DECEASED (Type or Print) <u>Mr. LITSINGER, LEE</u>				2. DATE AND HOUR OF DEATH <u>7, 4, 1972</u> <u>9.45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto</u>			
5. SEX <u>MALE</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>10-19-13</u>		9. AGE (In years last birthday) <u>58</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>A. Lee Litsinger</u>			
14. MOTHER'S MAIDEN NAME <u>Tanguay, Margi orie</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>213 09 7121</u>				17. INFORMANT <u>Gertrude Litsinger</u> ADDRESS <u>1901 Rushley Road</u>			
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>A</u> (A) IMMEDIATE CAUSE <u>Acute Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Atherosclerotic heart disease</u> (B) <u>and pulmonary emboli</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>since 1969</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that he (this hospital) attended the deceased from <u>04-12-72</u> <u>1972</u> to <u>7-4</u> <u>1972</u> , that he (we) last saw the deceased alive on <u>7-4</u> <u>1972</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. Shocair</u>				23B. PHYSICIAN'S NAME (Type) <u>MAWYA SHOCAIR</u>		23C. DATE SIGNED <u>7.4.1972</u>	
23D. ADDRESS <u>U.M.D. UNION MEMORIAL HOSPITAL</u>				23E. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>			
23F. NAME OF REGISTRAR <u>Sidney Robinson</u>				23G. FUNERAL DIRECTOR <u>Mitchell Wiedefeld Home</u>			
23H. ADDRESS <u>6500 York Rd.</u>				23I. ADDRESS <u>6500 York Rd.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/8/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Taylor Ave Balto Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 06364		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06364	
1. NAME OF DECEASED (Type or Print)		OLIVE HELMRICH		2. DATE AND HOUR OF DEATH July 5, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 4545 Harford Road Baltimore, Maryland 21214		A. STATE Maryland B. COUNTY Baltimore			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4545 Harford Road			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-14-1902	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamtrist		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Massachusetts	
13. FATHER'S NAME Anderson		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-5302		17. INFORMANT Mr. Robert A. Helmrich, 1043 Maiden Choice La	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 153.9 I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: circumstances of the heart (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/22/69 19 to 12/10/71 19, that (I) (we) last saw the deceased alive on 12/10/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/6/72	
23C. PHYSICIAN'S NAME (Type) M. Friedman		23D. ADDRESS 5211 Harford Road, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-1972		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06365	
72 06365				72 06365	
BIRTH NO. STATE OF MARYLAND - DEPT				CERTIFICATE OF DEATH	
1. NAME OF DECEASED ALSO KATHERINE G. CAVEY (Type or Print) CAVEY, CATHERINE GERTRUDE			2. DATE AND HOUR OF DEATH 07 05 72 9:55 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2006 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2750 WILKENS AVE - 21223		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 24 15	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY ICE CREAM	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE LUTZ			14. MOTHER'S MAIDEN NAME ELIZABETH REXROTH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 07 9579	17. INFORMANT ADDRESS ST AGNES HOSP RECORDS CATON & WILKENS AVE BALTIMORE MD 21229		
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE UNCAL HERNIATION DUE TO, OR AS A CONSEQUENCE OF: (B) METASTATIC CARCINOMA TO BRAIN DUE TO, OR AS A CONSEQUENCE OF: (C) CARCINOMA OF BREAST.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NOT AVAILABLE AT PRESENT.	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XIX (this hospital) attended the deceased from 07 03 1972 to 07 05 1972, that XIX (we) last saw the deceased alive on 07 05 1972 and that in XIX (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) XIX view the body after death.					
23A. SIGNATURE Robert W. Ashmore MD				23B. DATE SIGNED 7/5/72	
23C. PHYSICIAN'S NAME (Type) ROBERT W. ASHMORE M.D.				23D. ADDRESS BALTIMORE MARYLAND 21229 ST AGNES HOSPITAL CATON & WILKENS AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-1972		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. JUN 10 1972			
25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

UNITED STATES OF AMERICA
NAVY
OFFICE OF THE CHIEF OF NAVAL PERSONNEL

OFFICE OF THE CHIEF OF NAVAL PERSONNEL
1000 ...
WASHINGTON, D.C. 20374

1000 ...

1000 ...

1000 ...

1000 ...

1000 ...

1000 ...



YES

1000 ...

1000 ...

1000 ...

1000 ...

1000 ...

1000 ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 06366
BIRTH NO. T-120		STATE OF MARYLAND-DEM		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
GEORGE GROVER TEVES		July 4, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 1507 De Soto Road Baltimore, Maryland 21230		A. STATE Maryland B. COUNTY		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1507 De Soto Road		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-1885	9. AGE (In years last birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Teves		
14. MOTHER'S MAIDEN NAME Magdalena (Unknown)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-01-0913		17. INFORMANT ADDRESS Mrs. Sophie W. Teves, 1507 De Soto Rd. 21230		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction, probable ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis, generalized		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours? years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cerebrovascular Insufficiency		years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from 6/1/72 19 72 to 7/1/72 19 72 , that (I) (we) last saw the deceased alive on 7/1/72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Rifat Abousy MD		23B. DATE SIGNED 7/5/72		
23C. PHYSICIAN'S NAME (Type) Rifat Abousy		23D. ADDRESS 2300 Garrison Blvd., Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-1972		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery
24D. LOCATION (City, town, or county) (State) Washington Blvd. Howard Co., Md.				
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR William Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229

AND

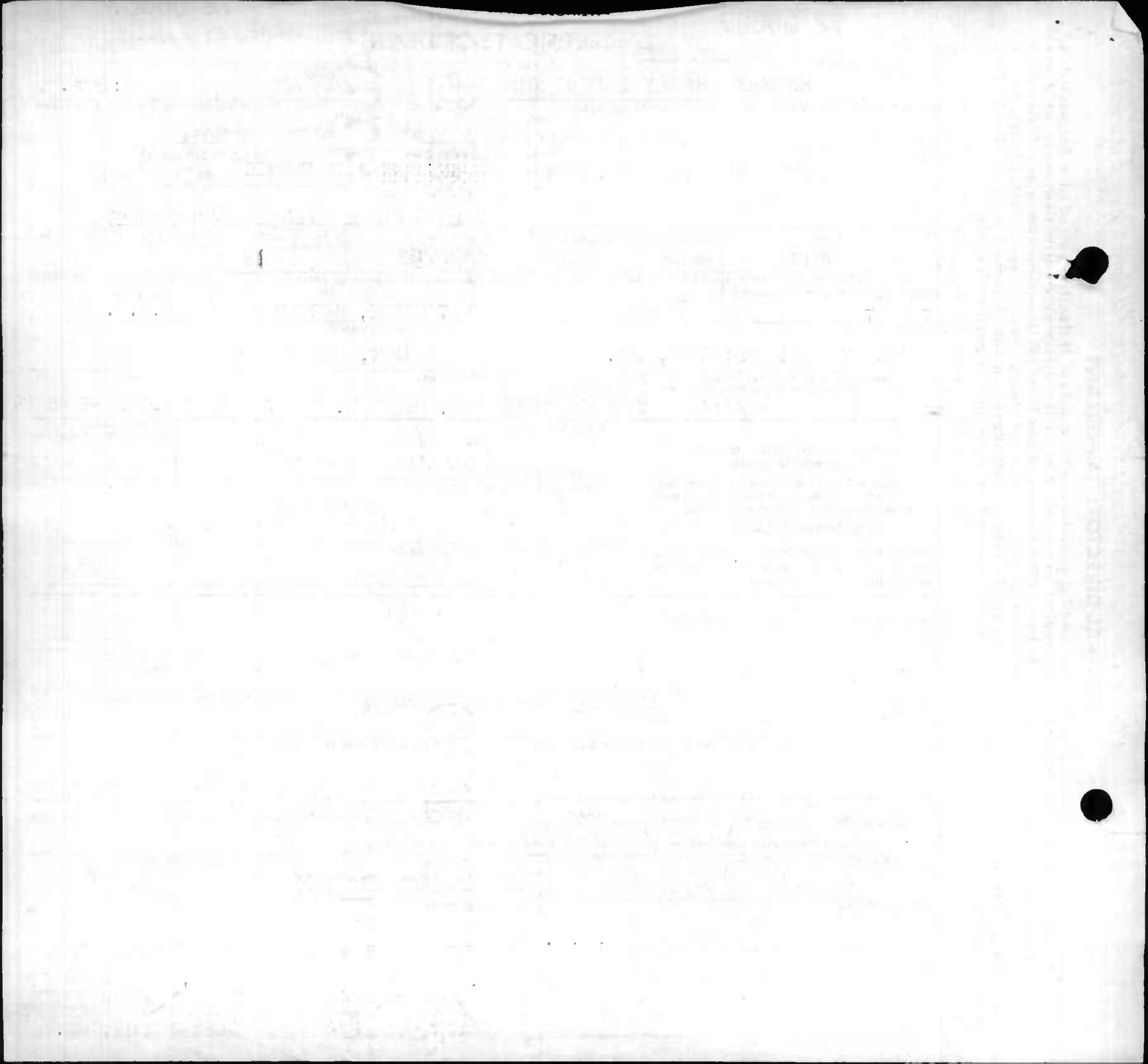
AND

Released - Now Med. by Mr. Mallory per Mr. Givens

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				72 06367		72 06367	
BIRTH NO.				STATE OF MARYLAND - DMMH		REG. NO.	
1. NAME OF DECEASED (Type or Print)				HARRY ERNEST CLIFTON		2. DATE AND HOUR OF DEATH 7/6/72 9:20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN GLEN BURNIE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 8 BALTIMORE AVENUE (FERNDAL)			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/2/52	9. AGE (In years last birthday) 19	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT				10B. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (State or foreign country) FORT MEADE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME HARRY PAUL CLIFTON, JR.			
14. MOTHER'S MAIDEN NAME GAUER, HELEN				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 214 62 1683				17. INFORMANT MRS. HELEN G. CLIFTON (mother) SAME AS #4			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Hemorrhage into (L) lung -> hypoxia (C) DUE TO, OR AS A CONSEQUENCE OF: A thoracotomy Fibrinous Adhesions			
19A. DATE OF OPERATION 7/6				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fibrinous adhesions			
20A. AUTOPSY (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased, from 7/4 1972 to 7/6 1972 that (I) (we) lost saw the deceased alive on 7/6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Fred Wingard			
23B. DATE SIGNED 7/6/72				23C. PHYSICIAN'S NAME (Type) Fred Wingard M.D.			
23D. ADDRESS J.H.H.				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE JULY 10/72				24C. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK			
24D. LOCATION GLEN BURNIE, MARYLAND				25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972			
25B. NAME OF REGISTRAR Frederick J. Thornton				25C. FUNERAL DIRECTOR R. J. Wright			
25D. ADDRESS SINGLETON FUNERAL HOME GLEN BURNIE, MD.							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620 72 06368		BALTIMORE CITY HEALTH DEPARTMENT		72 06368	
BIRTH NO. Wm. Bryan Price		CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <u>William Bryan Price (PRICE)</u>		2. DATE AND HOUR OF DEATH <u>5 JULY 72 1:00 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u> <u>38</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>QUEEN ANNE'S CO-6700</u> C. CITY OR TOWN <u>Chestertown</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Rt. 1, Box 187</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 JUN 31</u>	9. AGE (In years, lost birth day) <u>41</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Land Fill Attendant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Queen Anne Co. Quarry</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>W. Bryan Price, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>MARY FAULKNER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217 36 0153</u>		17. INFORMANT <u>Mrs. Patricia Price</u> ADDRESS <u>RFD Queen Anne Co Chestertown, Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>162-1 I</u> <u>ADENOCARCINOMA of the Lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>5 months</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ADENOCARCINOMA of the Lung</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) 	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>38 MAY 19 72</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from <u>38 MAY 19 72</u> to <u>5 JUL 19 72</u> that (we) last saw the deceased alive on <u>5 JUL 19 72</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Walker Lee Robinson MD</u>		23B. DATE SIGNED <u>5 JUL 72</u>		23C. PHYSICIAN'S NAME (Type) <u>WALKER LEE ROBINSON MD</u>	
23D. ADDRESS <u>University Hosp, Balto. Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/8/72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Chester Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>	
25B. NAME OF REGISTRAR <u>L. J. Well</u>		25C. FUNERAL DIRECTOR <u>L. J. Well</u>		ADDRESS <u>Chestertown, Md.</u>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. R-200 STATE OF MARYLAND-DEMH

REG. NO.

1. NAME OF DECEASED (Type or Print) ANDREW ROSE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 CITY HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1972 3:31 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2646			
6. SEX Male	7. RACE White	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH July 2 1901	10. AGE (In years lost birthday) 71 70	E. STREET AND NUMBER 6723 Graceland Avenue	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Anthony Rose		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethel Steel Co	
15. MOTHER'S MAIDEN NAME Lena Chymenski		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 213 09 0610		18. INFORMANT ADDRESS Mrs. Anthony Rose 6723 Graceland Avenue	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/5/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-72	
24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT JUN 10 1972		25B. NAME OF REGISTRAR <i>Sidney H. Hooton</i>	
25C. FUNERAL DIRECTOR WALTER DABROWSKI 1005 DUNDALK AVENUE		ADDRESS	

WALTER P. GILBERT

WALTER P. GILBERT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
T-200 72 06370					REG. NO. 72 06370					
STATE OF MARYLAND - DEATH					BIRTH NO.					
1. NAME OF DECEASED (Type or Print) THEIS, GEORGE ALFRED					2. DATE AND HOUR OF DEATH JULY 6, 1972 6:30A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN HIGHLAND D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER RT 108					
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08 16 08	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR			10B. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE THEIS					14. MOTHER'S MAIDEN NAME DOROTHY (SIEWERTS)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213035239		17. INFORMANT RECORDS OF ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO. MD. 21229					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 518X 17-161-9 Bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchiectasis (B) DUE TO, OR AS A CONSEQUENCE OF: Carcinoma larynx irradiated 1964 (C) Carcinoma @lung - operation 1970					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from JUNE 30 19 72 to JULY 6 19 72 , that (I) (we) last saw the deceased alive on JULY 6 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Joseph H. Miller, MD					23B. DATE SIGNED 7-9-72			23C. PHYSICIAN'S NAME (Type) J MILLER, M.D.		
23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229					23E. ADDRESS SLACK Funeral Home, Ellicott City, Md. 21043					
24A. BURIAL CREMATION, REMOVAL (Specify) burial			24B. DATE 7/10/72			24C. NAME OF CEMETERY OR CREMATORY St. Paul Lutheran Cem.			24D. LOCATION (City, town, or county) (State) Fulton, Howard Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972			25B. NAME OF REGISTRAR Sidney H. Hinton			25C. FUNERAL DIRECTOR SLACK Funeral Home, Ellicott City, Md. 21043				

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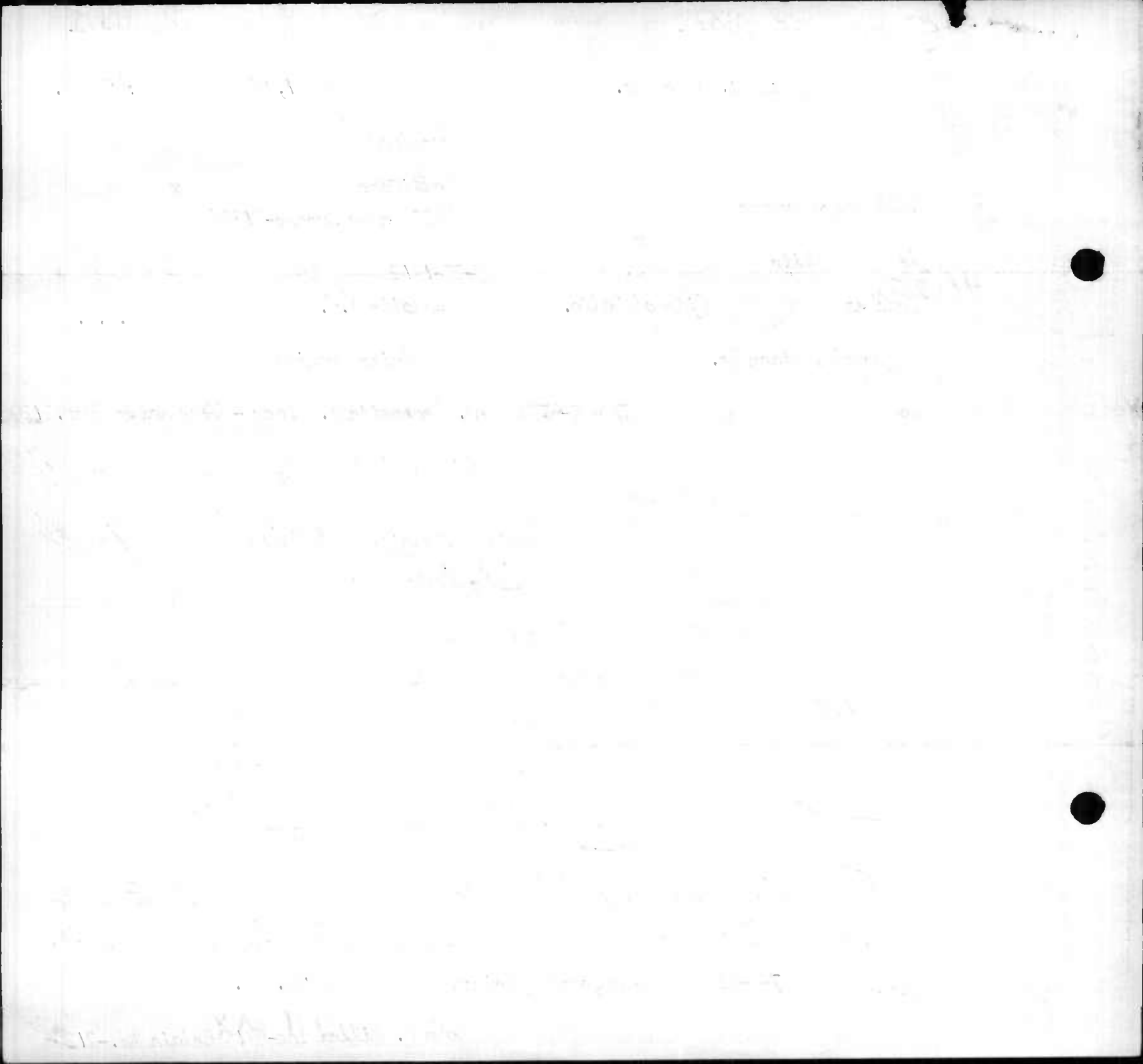
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

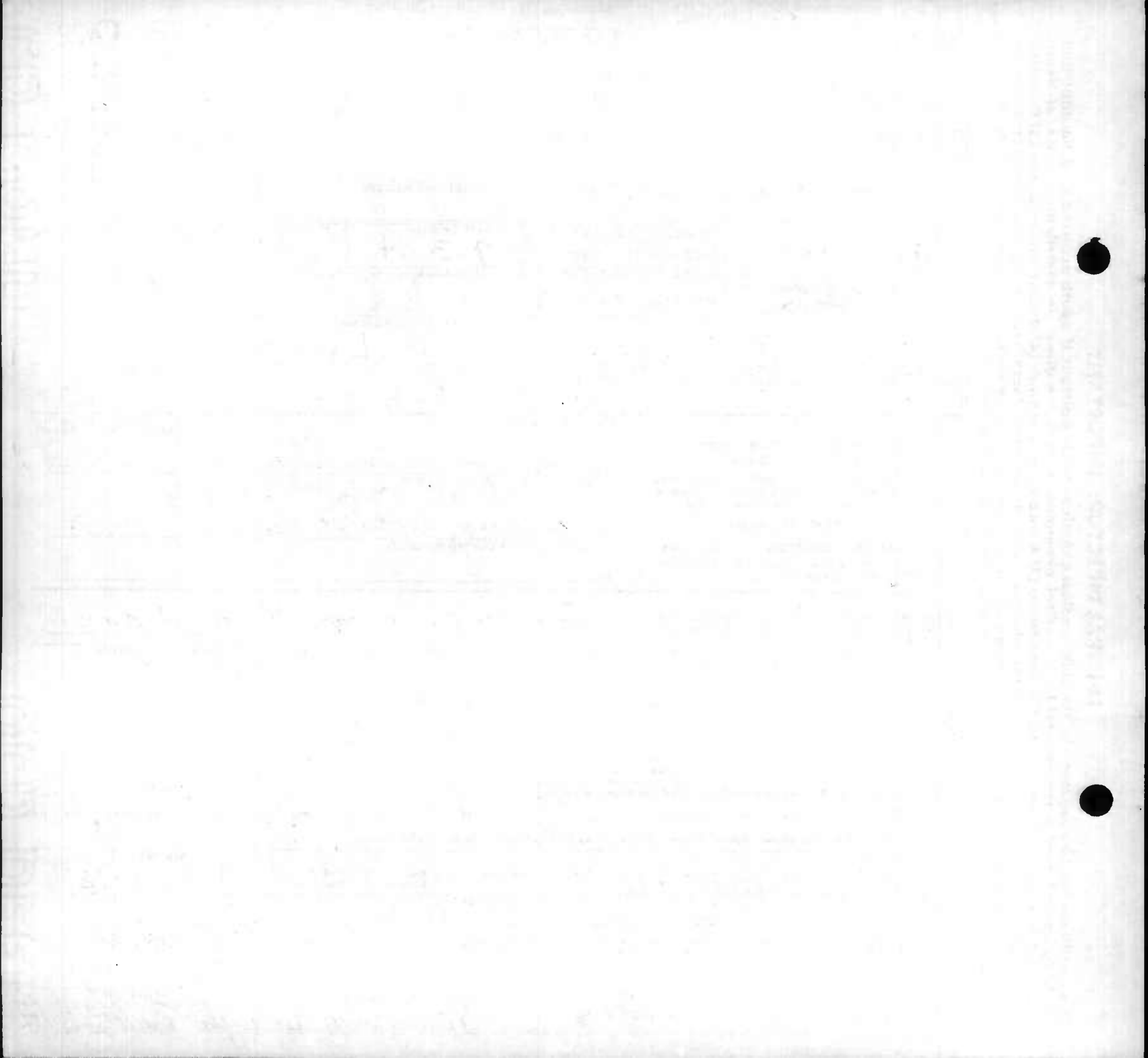
S-320 72 06371		BALTIMORE CITY HEALTH DEPARTMENT		72 06371	
BIRTH NO.		STATE OF MARYLAND-DEME		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.	
Edward I. Stacy Jr.		July 1, 1972		4:45 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY 2631		C. CITY OR TOWN Baltimore	
4422 Raspe Avenue		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 4422 Raspe Avenue-21206	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1912	9. AGE (In years last birthday) 60	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY City of Balto.		11. BIRTHPLACE (State or foreign country) Charlotte N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward I Stacy Sr.		14. MOTHER'S MAIDEN NAME Claire Hawkins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-05-8773		17. INFORMANT Mrs. Jeannette S. Stacy - 4422 Raspe Aven. 21206	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 188X I CAUSE OF DEATH Melastole Carcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mth			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Bladder		(B) DUE TO, OR AS A CONSEQUENCE OF: Bladder	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Anemia					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1970 to July 1972 that (I) last saw the deceased alive on 6-26-1972 and that (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE R. L. Doyle MD		23B. DATE SIGNED 7-3-72			
23C. PHYSICIAN'S NAME (Type) R. L. DOYLE MD		23D. ADDRESS 222 ST. PAUL ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3-6-72		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Sidney Horton	
25C. FUNERAL DIRECTOR John C. Miller Inc		25D. ADDRESS 6415 Belair Rd - 21206			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-250</u>		STATE OF MARYLAND - DHMH		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>72 06372</u>	
1. NAME OF DECEASED (Type or Print) <u>Mr John W. McKeown</u>				2. DATE AND HOUR OF DEATH <u>7-3-72</u> <u>1 07</u> P. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>34 Bon Secours Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Edmondson Ave, Md</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u>				C. CITY OR TOWN <u>Catonsville</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>5300</u>									
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-3-14</u>		9. AGE (In years last birthday) <u>58</u>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WORKS NOT FOR BLIND</u>				11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Owen McKeown</u>				14. MOTHER'S MAIDEN NAME <u>MARY LAWLER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-243641</u>		17. INFORMANT <u>Mrs. Mary McKeown - 206 Edmondson Ave</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4/23 1st 1884</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Subendocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ant wall + interventricular Septum</u> (B) <u>Arteriosclerotic H. Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>years</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Carcinoma of urinary bladder</u>						<u>1 year</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <u>N</u> (this hospital) attended the deceased from <u>7-1</u> 19 <u>72</u> to <u>7-3</u> 19 <u>72</u> that <u>N</u> (we) last saw the deceased alive on <u>7-3</u> 19 <u>72</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>N</u> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Sin SETHAVORAVICHIT MD</u>				23B. DATE SIGNED <u>7-3-72</u>				23C. PHYSICIAN'S NAME (Type) <u>SIN SETHAVORAVICHIT</u>	
23D. ADDRESS <u>Bon Secours Hospital</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-7-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>		25B. NAME OF REGISTRAR <u>Harley Lavanough</u>		25C. FUNERAL DIRECTOR <u>Frederick R.</u>		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06373	
X-656 72 06373		STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MARY E. KRAMER		JULY 4, 1972		9.50 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 4719 FREDERICK AVE.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MD. 2531			
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH AUG. 24, 1896		9. AGE (In years last birthday) 75		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME OLIVER BENSON		14. MOTHER'S MAIDEN NAME CARRIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Fulton A. Kramer Jr., 1028 Woodson Rd.	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Metastatic Cr. of Lung DUE TO, OR AS A CONSEQUENCE OF: (B) Bronchogenic Carcinoma DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. 1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 9 1945 to July 4 1972, that (I) (we) last saw the deceased alive on July 3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.					
23A. SIGNATURE Wilmer K. Gallagher, M.D.		23B. DATE SIGNED 7-5-72		23C. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, M.D.	
23D. ADDRESS 6209 Frederick Ave., Balt., Md. 21228		23E. FUNERAL DIRECTOR Fulton A. Kramer Jr., 1028 Woodson Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-72		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM.	
24D. LOCATION Baltimore Md.		24E. NAME OF REGISTAR JUL 10 1972			
25A. DATE OF DEATH JUL 10 1972		25B. NAME OF REGISTAR Fulton A. Kramer Jr., 1028 Woodson Rd.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06374	
BIRTH NO. <u>P-141</u>		STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>William P. Poplovski</u> <u>WILLIAM Poplovski</u>		2. DATE AND HOUR OF DEATH <u>7-4-72</u> <u>18 55 A.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME AND HOSPITAL</u> <u>35 BALTIMORE, MARYLAND</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6-29-18</u>		9. AGE (in years last birthday) <u>54</u>		10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED-STEELWK.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ANTON POPOLOVSKI</u>		14. MOTHER'S MAIDEN NAME <u>Klementine Hecko</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-6800</u>		17. INFORMANT Wife: <u>Mrs. Edna P. Poplovski</u> ADDRESS <u>409 Wolfe Street Essex, Md. 21221</u>	
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary heart disease, ACHD</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>61</u> to <u>present</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7-4</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George C. Roveti M.D.</u>		23B. DATE SIGNED <u>7/4/72</u>		23C. PHYSICIAN'S NAME (Type) <u>George C. Roveti M.D.</u>	
23D. ADDRESS <u>100 N. Broadway</u>		23E. FUNERAL DIRECTOR <u>John J. Duda</u>		23F. ADDRESS <u>7922 Wise Ave. Dundalk, Md. 21222</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-7-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. NAME OF REGISTERAR <u>John J. Duda</u>		24F. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>	

Gooder. Robert H.D. 100 N. B. Street
New Orleans, La.

7-4

1-4-42

21 Street

Gooder. Robert H.D. 100 N. B. Street

Gooder. Robert H.D. 100 N. B. Street

12-4-42

Gooder. Robert H.D. 100 N. B. Street

Gooder. Robert H.D. 100 N. B. Street

12-4-42

Gooder. Robert H.D. 100 N. B. Street

C-208

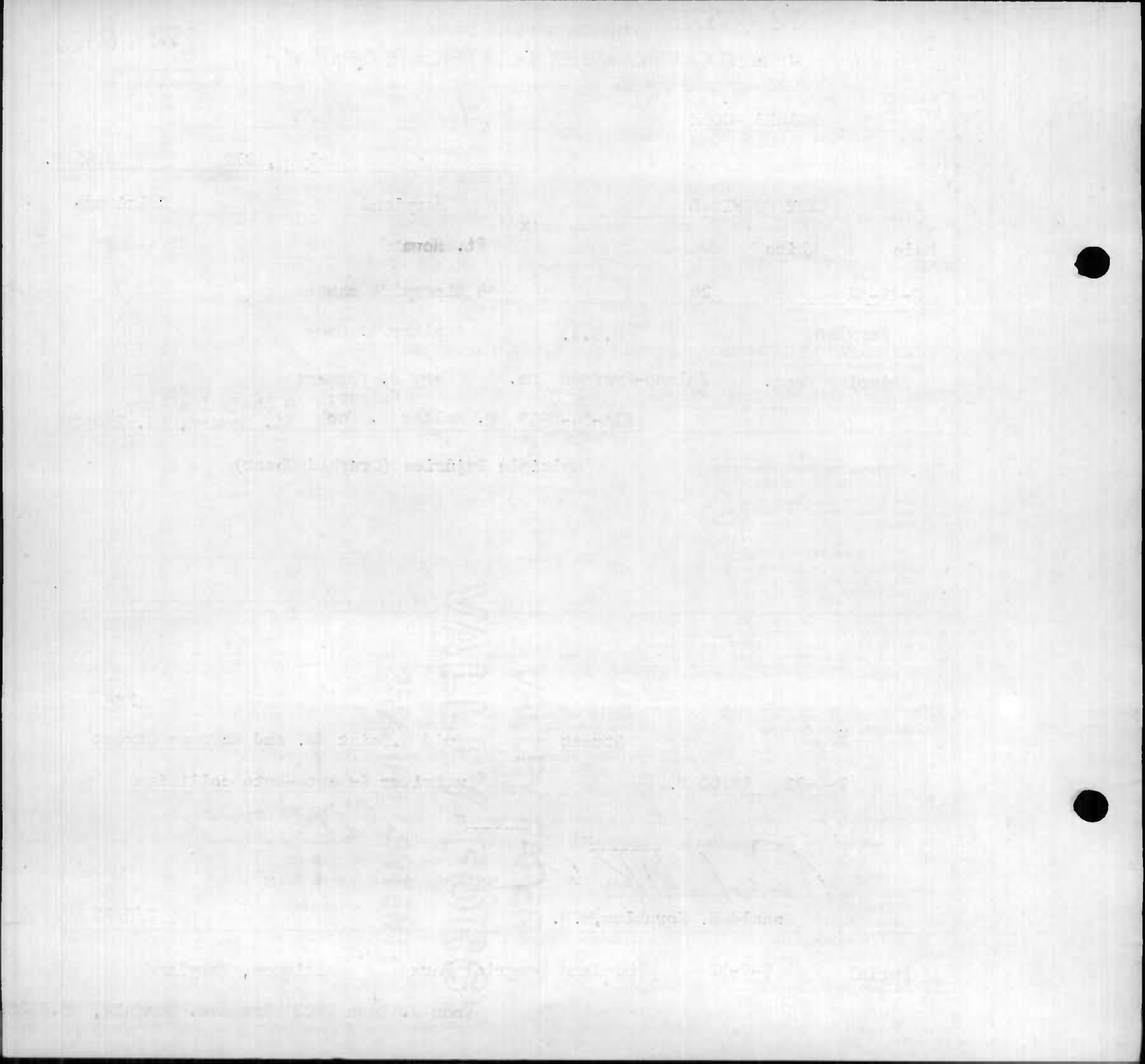
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

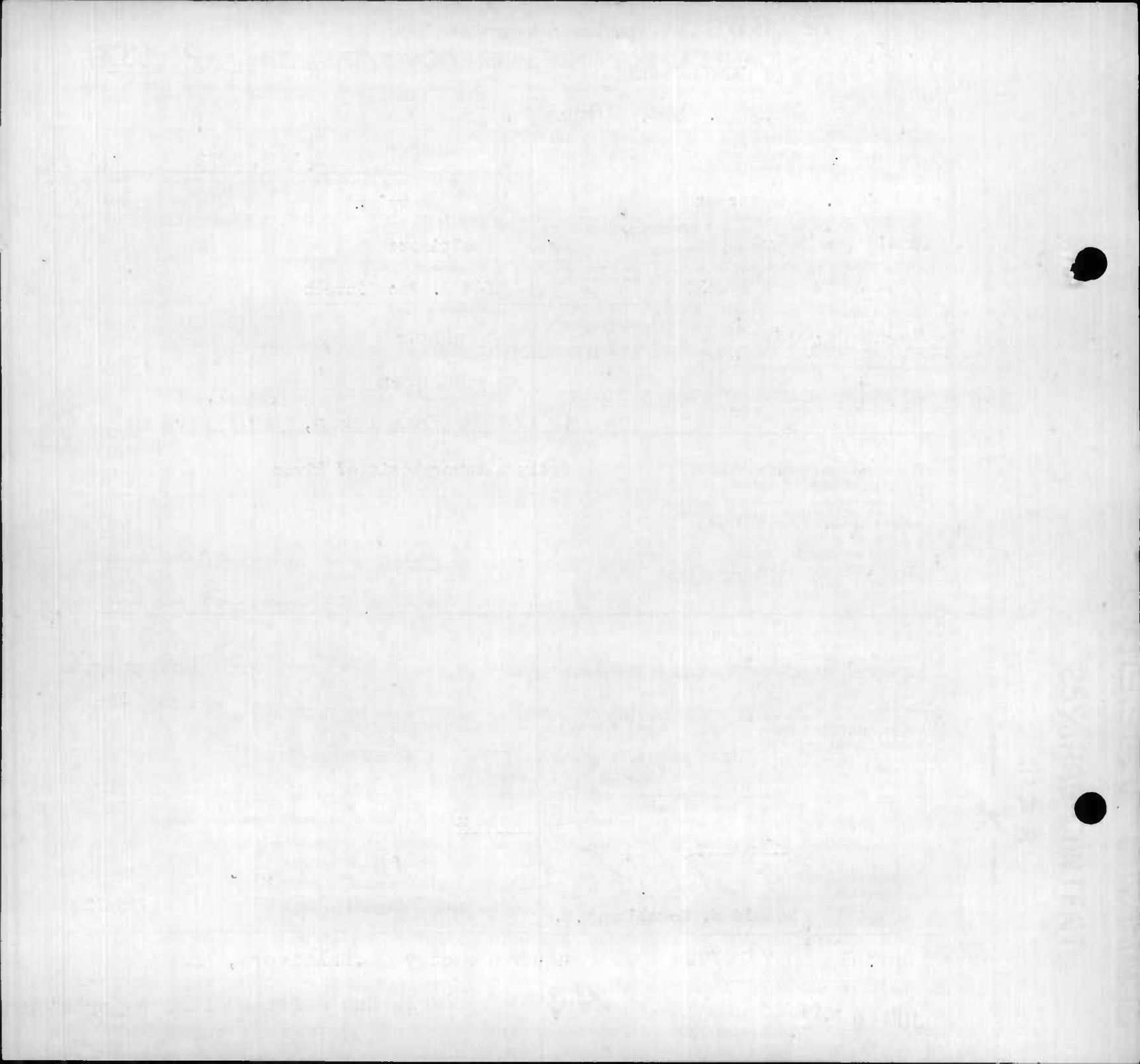
BIRTH NO.

STATE OF MARYLAND-UMMD

1. NAME OF DECEASED (Type or Print) NORRIS COOK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year July 4, 1972		3. DATE PRONOUNCED DEAD Month Day Year July 4, 1972		4. TIME PRONOUNCED DEAD Hour 10:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 CITY HOSPITAL		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY Baltimore		6. CITY OR TOWN Ft. Howard	
6. SEX Male		7. RACE White		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 2-22-52		10. AGE (In years last birthday) 20		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 4 Shadyside Lane	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter H. Cook		15. MOTHER'S MAIDEN NAME Mary J. Thamer	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Dept.		14B. KIND OF BUSINESS OR INDUSTRY Inland-Ryerson Inc.		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-64-8917	
18. INFORMANT Father: Mr. Walter H. Cook		ADDRESS 4 Shadyside Lane Ft. Howard, Md. 21052		19. CAUSE OF DEATH Multiple Injuries (Crushed Chest)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple Injuries (Crushed Chest)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Old N. Point Rd. and McComas Street		21. AUTOPSY? (Yes or No) yes	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-4-72 10:00 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver in auto-auto collision		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/5/72		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 7-7-72		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972	
25B. NAME OF REGISTRAR Anthony Johnson		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md. 21222		25D. NAME OF REGISTRAR Anthony Johnson	



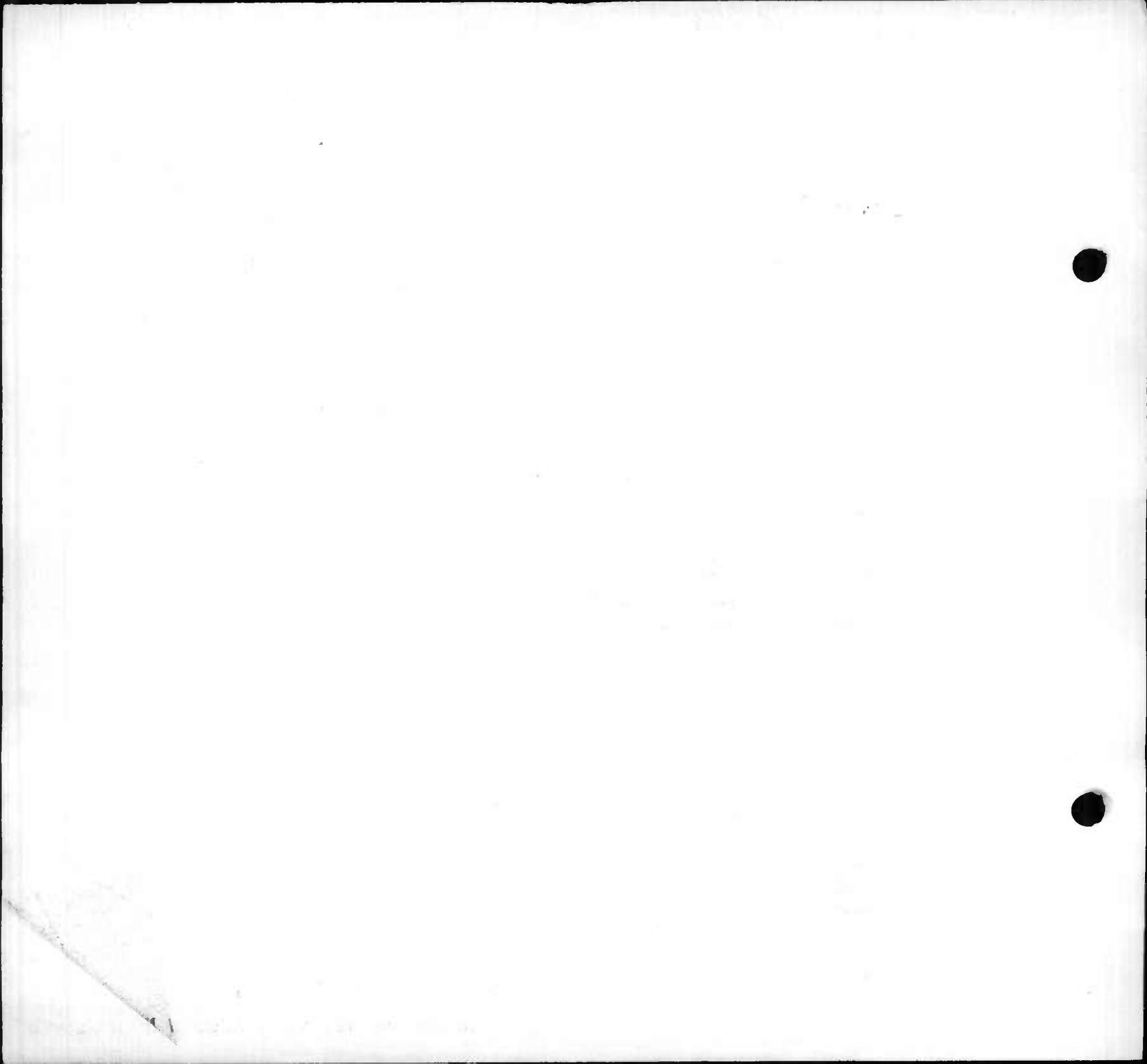
BIRTH NO.		STATE OF MARYLAND-DEMR		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) EMMA L. NONNE (NUNN)				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 4, 1972 7:50 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 540 S. Paca Street				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2101		6. SEX Female 7. RACE Negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH 6/5/32		10. AGE (In years lost birthday) 30		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Unknown	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Unknown			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr Zeke Lewis, 540 N Paca St			
19. 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/5/72			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		7/10/72		MT Auburn Cemetery		Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 10 1972		Audrey Whitson		Adolphus Halstead		1206 W North			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> R-263 72 06377 BALTIMORE CITY HEALTH DEPARTMENT 72 06377 </div>	
CERTIFICATE OF DEATH	
BIRTH NO. STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) RICHARDSON Samuel	
2. DATE AND HOUR OF DEATH 5pm 2 July 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital 42	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2716	
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4733 Park Heights Ave	
5. SEX male	6. RACE black
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1919 3 MARCH	
9. AGE (In years last birthday) 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman	
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RICHARDSON NOAH	
14. MOTHER'S MAIDEN NAME HOLMES - ELLA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 218-01-8086	
17. INFORMANT Chart ADDRESS	
18. 436.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE CEREBRO VASCULAR ACCIDENT ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERTENSION	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 June 1972 to 2 July 1972 that (I) (we) last saw the deceased alive on 2 July 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Gian Caggiano M.D.	
23B. DATE SIGNED 2 July 1972	
23C. PHYSICIAN'S NAME (Type) Gian Caggiano M.D.	
23D. ADDRESS Sinai Hospital, Balto MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 7/6/72	
24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972	
25B. NAME OF REGISTRAR Adolphus Halstead	
25C. FUNERAL DIRECTOR Adolphus Halstead ADDRESS 1206 W North Ave	



1

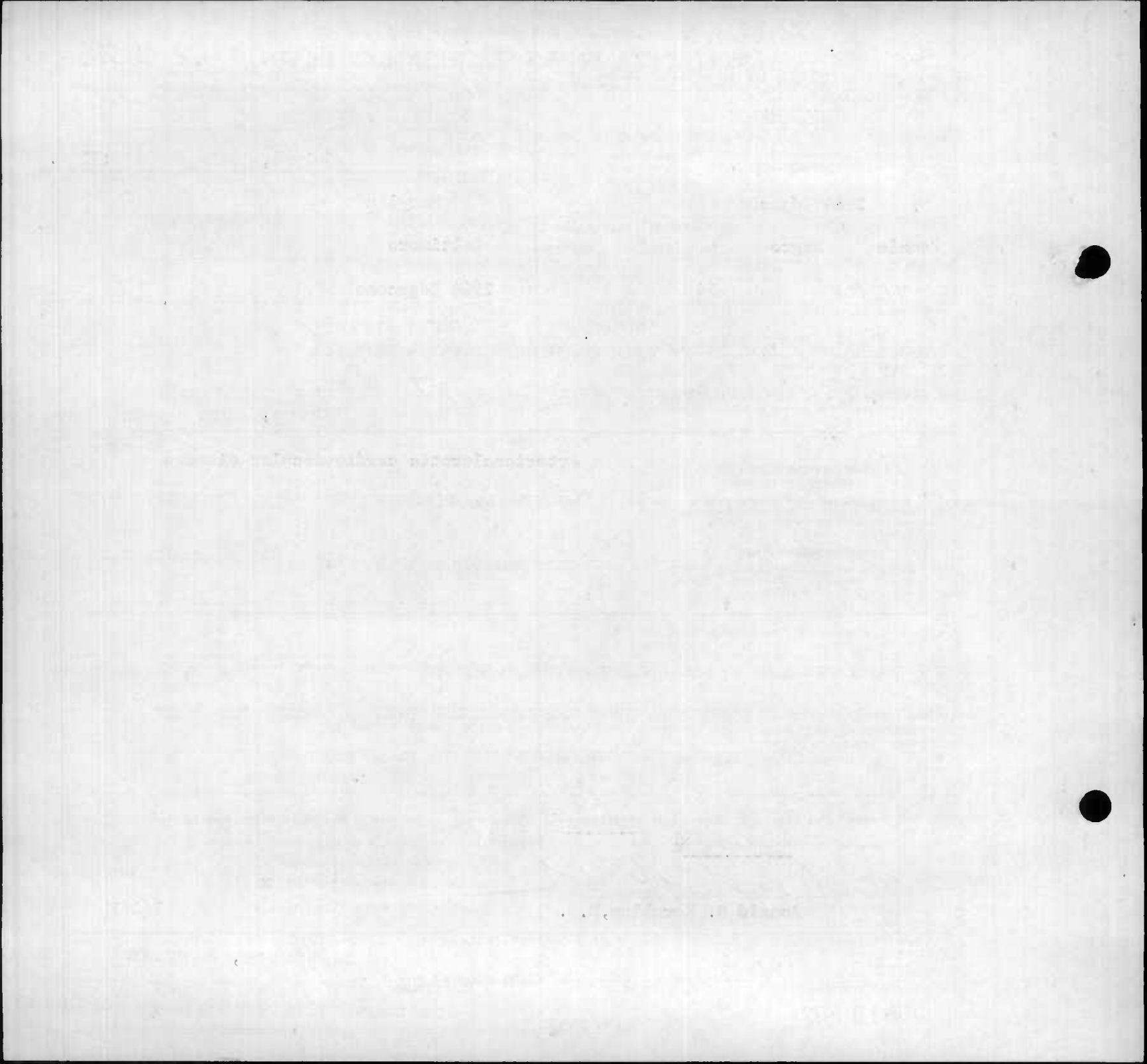
M-250 72 06378 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 72 06378

BIRTH NO. STATE OF MARYLAND-DRM REG. NO.

1. NAME OF DECEASED (Type or Print) EDNA MASON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2944 Edgemoor		3. DATE PRONOUNCED DEAD Month Day Year Hour July 4, 1972 9:12 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7/1/98		10. AGE (In years lost birthday) 74	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Stewart		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Mary Green		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs Warren, 2909 Dupont Ave	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 7/4/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Av	

VS 151-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-300 72 06379		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 8-33 72 06379	
BIRTH NO.		STATE OF MARYLAND-DEM		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Myatt David		7/3/72		1:55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
George Washington Nursing Home		Balt City		1701	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		607 Pennsylvania Ave			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: Hours: Min.
Male	Black	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	April 20 1911	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				Newberry S.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Sam Myatt		Lulu Byrd		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMATION ADDRESS	
		577-18-7597		Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DIABETES MELLITUS		12 YRS.	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
		SUBARACHTNOID		10 YRS.	
		HEMORRHAGE			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		HASCUS			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 24 MAY 19 69 to 3 JULY 19 72 that (1) (we) last saw the deceased alive on 3 JULY 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Richard E. Tyson, MD		3 July 72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Richard E. Tyson MD		936 West North Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/7/72		MT Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 10 1972		Richard E. Tyson		A Halstead 1206 W North Ave	

6/13/67 - Adm date Geo. Washington N. H.

W-330

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. STATE OF MARYLAND-DEME

1. NAME OF DECEASED (Type or Print) VICTOR J. WHITEHEAD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour June 26, 1972 12:15 A.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1506	
9. DATE OF BIRTH July 27, 1911		10. AGE (In years last birthday) 61	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Oliver Macklin		14. MOTHER'S MAIDEN NAME Carolyn Whitehead	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Victor Whitehead		18. ADDRESS 3006 W. North Ave. East	

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Malnutrition and dehydration			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3006 W. North Avenue 1506	
22D. TIME OF INJURY (APPROX.) Unknown		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Neglect	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.	
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 6/27/72	

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/72		24C. NAME OF CEMETERY or CREMATORY Calvary		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Dorothy Johnson		25C. FUNERAL DIRECTOR Chas. L. Macgregor		ADDRESS 3006 W. North Ave. East	

VALLEY FORGE

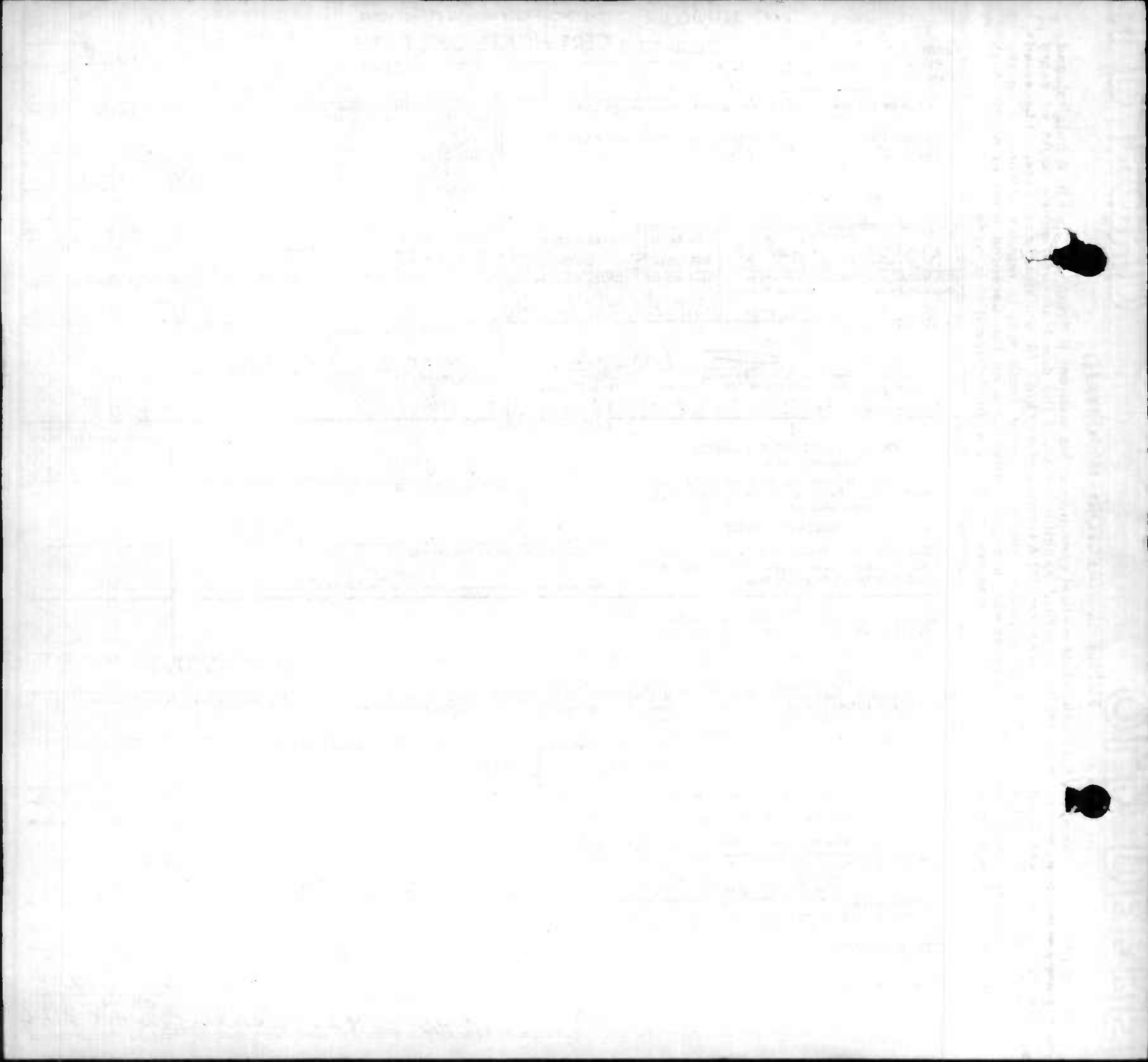
COZYDA UNIT

Received of the
Valley Forge
Cozyda Unit
the sum of \$100.00
for the purpose of
the purchase of
the land on which
the Cozyda Unit
is located.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-540 72 06381		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.
BIRTH NO.		STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>Donnelly, Edward George</u>		2. DATE AND HOUR OF DEATH <u>7/6/72</u> <u>9:05</u> <u>P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>South Baltimore General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence, before admission) A. STATE <u>Md.</u> B. COUNTY <u>1</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>3115 Fairhaven Ave.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-16-13</u>	9. AGE (In years last birthday) <u>59</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security guard</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Motor Vehicle adm.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Donnelly</u>		
14. MOTHER'S MAIDEN NAME <u>Sophie Nengel</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>None 216 to 5848</u>		
16. SOCIAL SECURITY NO. <u>21610-5848</u>		17. INFORMANT <u>Phil Woo Song</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>54 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Brain tumor metastatic melanoma</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>6/2/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain tumor melanoma</u>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> 19 <u>72</u> to <u>7/6/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/6</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Phil Woo Song</u>		23B. DATE SIGNED <u>7/6/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Phil Woo Song</u>
23D. ADDRESS <u>SBGH</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
24B. DATE <u>7-10-72</u>		24C. NAME of CEMETERY or CREMATORY <u>HOLY CROSS</u>		24D. LOCATION (City, town, or county) (State) <u>Ritchie Hwy. BALTO. MD.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Johnston</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Hahn 4200 PENNINGTON AVE. 21226</u>



BIRTH NO.		STATE OF MARYLAND-DEATH		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
U-651		72 06382		72 06382					
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year		Estimated <input type="checkbox"/> Hour M.	
MOTIEJOS URNEVICIUS				3. DATE PRONOUNCED DEAD		Month Day Year		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION				6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
38 UNIVERSITY HOSPITAL				Male		White		Maryland	
9. DATE OF BIRTH				10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
11/4/1991				81		Lithuania		U.S.A.	
13. FATHER'S NAME				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
42 Parkin Street				Tailor		Unknown		No	
17. SOCIAL SECURITY NO.				18. INFORMANT		19. CAUSE OF DEATH I		20. DATE OF OPERATION	
				Motilda Graham		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		21. AUTOPSY? (Yes or No)	
				250A Holly Beach Ave		(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		yes	
						(A) IMMEDIATE CAUSE			
						Bronchopneumonia			
						DUE TO, OR AS A CONSEQUENCE OF:			
						(B) Arteriosclerotic cardiovascular disease			
						DUE TO, OR AS A CONSEQUENCE OF:			
						(C)			
						II			
						OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
						22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
						22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
						22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
						23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
						24. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
						burial		7/11/72	
						24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
						Holy Redeemer		Baltimore, Md.	
						25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
						JUN 10 1972		Sidney W. Weston	
						25C. FUNERAL DIRECTOR		25D. ADDRESS	
						John J. Cowan & Son, Inc.		901 Hollins St. Balto. Md. 21203	

8-3-1972 - Completion of cause of death on a pending medical examiner death certificate
Ronald N. Kornblum, M.D. HRS

Released As Non Medical Exam. Per Mr. Gregory.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-436 72 06383

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 06383

STATE OF MARYLAND=DHMH

BIRTH NO. 1

1. NAME OF DECEASED (Type or Print) ~~Dexter~~ ~~Dexter~~ ~~#~~ COULTER, GUS

2. DATE AND HOUR OF DEATH 7-7-72 3:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md B. COUNTY 402

5. SEX M 6. RACE W 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH Dec. 25, 1900 9. AGE (In years last birthday) 71 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 11. BIRTHPLACE (State or foreign country) Kentucky 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Harry A. Coulter 14. MOTHER'S MAIDEN NAME Annie Anderson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT ADDRESS BALTO. CITY POLICE DEPT.

18. CAUSE OF DEATH 441-21

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Ruptured abdominal aortic aneurysm. DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 7-7-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured abdominal aneurysm 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-7-72 19 to 7-7-72 19 that (I) (we) last saw the deceased alive on 7-7-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

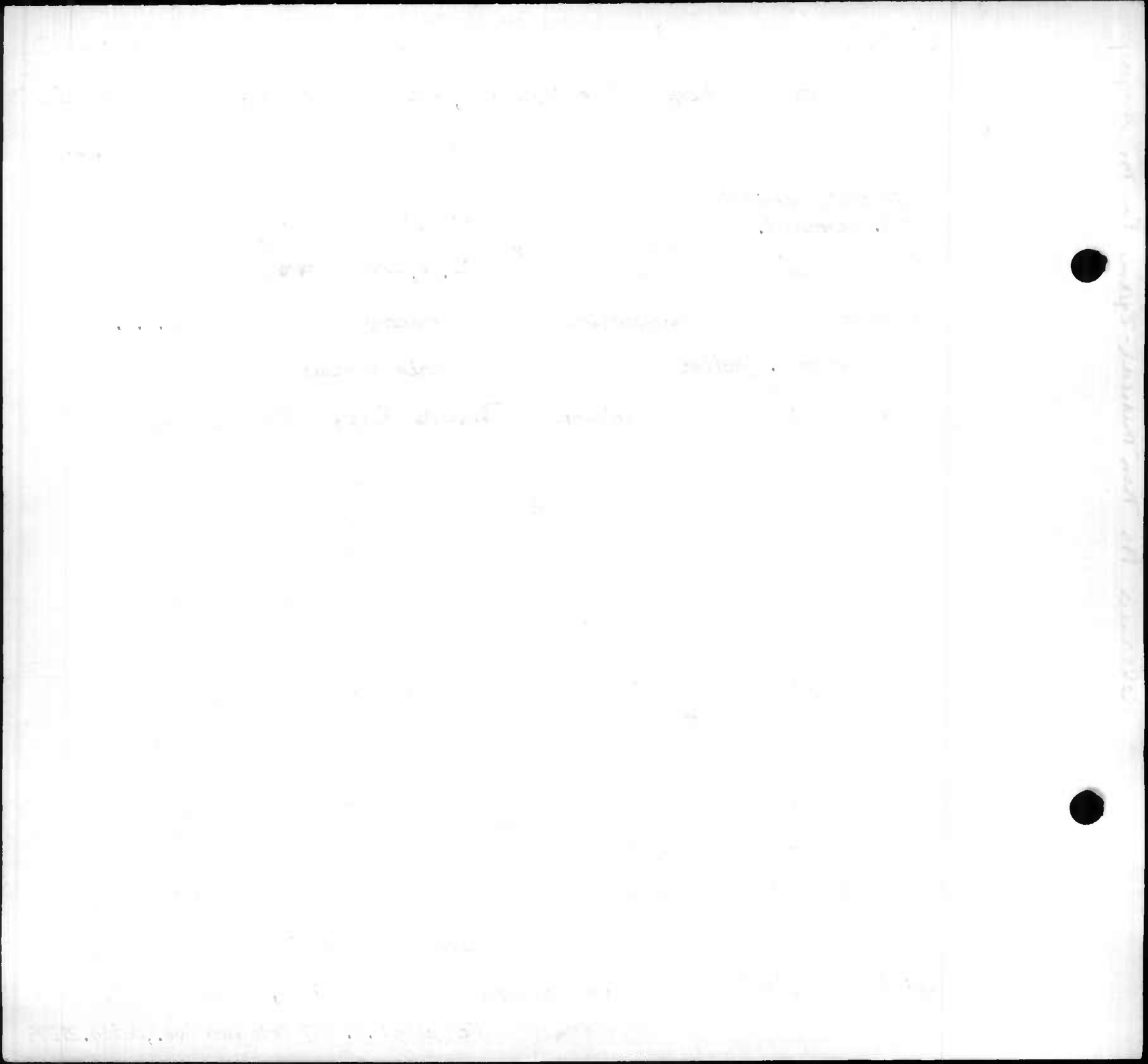
23A. SIGNATURE Michael P. Buchner M.D. DEGREE 23B. DATE SIGNED 7-7-72

23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS University Hospital DEGREE

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 7/10/72 24C. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery 24D. LOCATION (City, town, or county) (State) Mayfield, Kentucky

25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972 25B. NAME OF REGISTRAR Gregory H. Heston 25C. FUNERAL DIRECTOR ADDRESS McCully F.H. 237 Patapsco Ave., Balto. 21225

VS 150-REV. 1/1/68



1
H-200

B-560

72 06384

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06384

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) MARGARET BAYNOR (HAYES)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> July 6, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1637 N. Gilmore Street		3. DATE PRONOUNCED DEAD Month Day Year Hour July 6, 1972 12:28 P.	
6. SEX Female		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3/13/1944		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birth day) 28		E. STREET AND NUMBER 1637 N. Gilmore Street	
11. BIRTHPLACE (State or foreign country) BALTO MD		13. FATHER'S NAME Wm. D. Hayes Sr	
12. CITIZEN OF MD		15. MOTHER'S MAIDEN NAME Ella Johnson	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		17. SOCIAL SECURITY NO.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		18. INFORMANT Wm. D. Hayes Sr ADDRESS 312 S. Franklin	
19. 571.8		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 6, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/72	
24C. NAME OF CEMETERY OR CREMATORY MR DUBURN		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Andrew Johnson	
25C. FUNERAL DIRECTOR Marshall P. Lange		ADDRESS 688 N. Gilmore St	

AVAILABLE FOR

THIS OFFICE IS NOW OPEN

THE OFFICE IS NOW OPEN

THE OFFICE IS NOW OPEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06385	
B-650 72 06385				CERTIFICATE OF DEATH	
BIRTH NO. STATE OF MARYLAND-DEMH		1. NAME OF DECEASED (Type or Print) ONA C. BROWN		2. DATE AND HOUR OF DEATH 7-9-72 6:20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 701 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3020 Mc ELDERRY ST.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-04	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME AUGUSTUS MILLER		
14. MOTHER'S MAIDEN NAME AGNES (unk.)			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 217-05-2081			17. INFORMANT ADDRESS Doris Fuller Jones-3020 Mc Elderry St.		
18. CAUSE OF DEATH 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Respiratory Arrest (B) (Malignant) Carcinoma Breast 5 yrs (C)					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 7 19 72 to July 9 19 72 and that (I) (we) last saw the deceased alive on July 9 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Long (phon) (unk.), M.D.				23B. DATE SIGNED 9 July 1972	
23C. PHYSICIAN'S NAME (Type) C. A. LOBBOCK		23D. ADDRESS M. D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/72		24C. NAME OF CEMETERY OR CREMATORY Loudon PK. Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Fred. D. Miller, Inc.	
25C. FUNERAL DIRECTOR ADDRESS 3019 E. Monument					

Y-1234

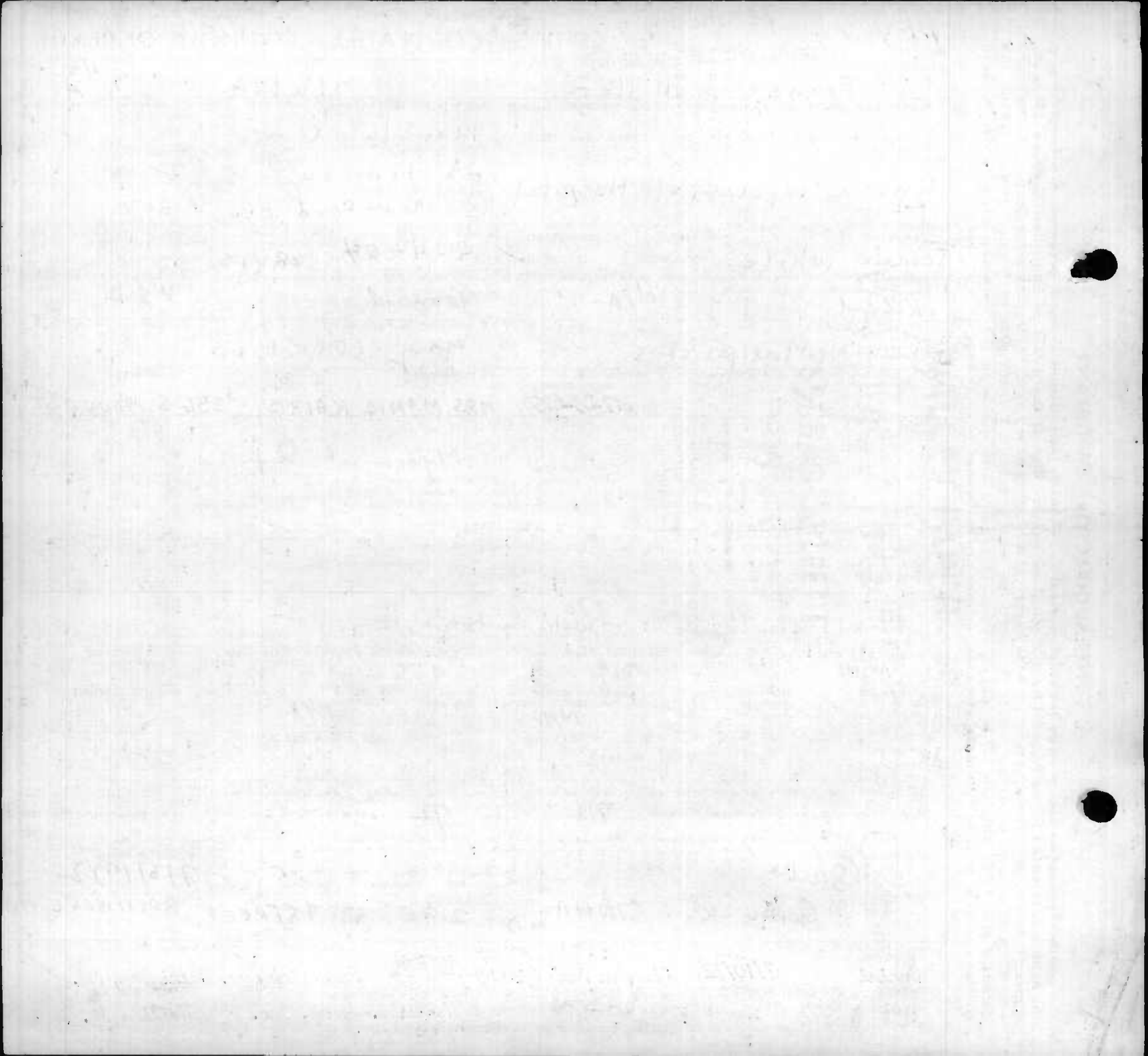
RECEIVED



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11-460 72 06386		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06386	
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. STATE OF MARYLAND - DEPT 1. NAME OF DECEASED (Type or Print) <u>Frances Miller</u> </div> <div> 2. DATE AND HOUR OF DEATH <u>7/6/72</u> <u>7:45</u> <u>A</u> M. </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> </div> <div style="flex: 1;"> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex;"> <div style="flex: 1;"> A. STATE <u>Maryland</u> </div> <div style="flex: 1;"> B. COUNTY <u>103</u> </div> </div>		
5. SEX <u>Female</u>			6. RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		8. DATE OF BIRTH <u>4-4-04</u>	
13. FATHER'S NAME <u>John N. Masijawskas</u>		14. MOTHER'S MAIDEN NAME <u>Mary Slawicki</u>		9. AGE (In years last birthday) <u>68 yrs.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-03-6250</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>V.S.A</u>		17. INFORMANT ADDRESS <u>MRS. MAMIE KAIRIS 336 S. MOUNT ST</u>			
18. CAUSE OF DEATH <div style="display: flex;"> <div style="flex: 1;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="flex: 1;"> (A) IMMEDIATE CAUSE <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="flex: 1;"> (B) DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="flex: 1;"> (C) </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Sudden death</u>					
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N/A</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N/A</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 7/6 _____ 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gopal K. Sinha</u>				23B. DATE SIGNED <u>7/6/1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>GOPAL K. SINHA M.D.</u>				23D. ADDRESS <u>219 E, 33rd STREET, BALTIMORE MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/10/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Frederick Ave. Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>			
25B. NAME OF REGISTRAR <u>Lidney</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Thomas J. Kerry, Inc. 1600 Hollins St. 21223</u>			



72 06387

BALTIMORE CITY HEALTH DEPARTMENT

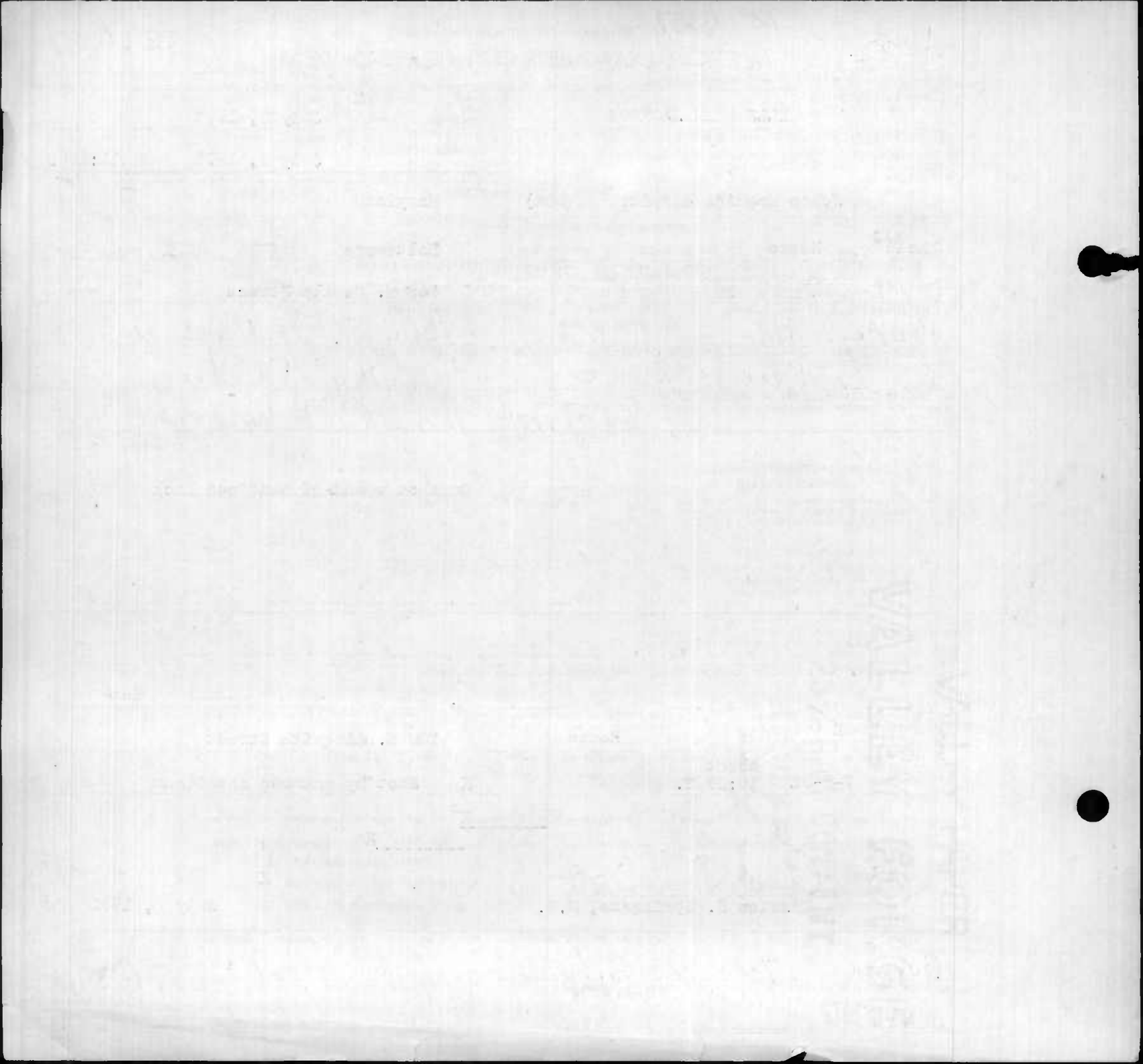
72 06387

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. STATE OF MARYLAND-DEMH

1. NAME OF DECEASED (Type or Print) ELLSWORTH JACKSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 5, 1972	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1972 11:19 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 704	
9. DATE OF BIRTH 6-14-1942		10. AGE (In years last birthday) 30	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ellsworth Jackson Sn.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Employee	
15. MOTHER'S MAIDEN NAME Worothy Sanders		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 214-38-1871		18. INFORMANT Worothy Jackson	
19. CAUSE OF DEATH E965X		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Gunshot wounds of head and back DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 200 N. Aisquith Street		22D. TIME (Month) (Day) (Year) (Hour) (Minute) 7-5-72 10:33 P. M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 6, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-72	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Dudney Johnson	
25C. FUNERAL DIRECTOR Cheney O. Wilson		ADDRESS 1600 B. and Carey Ave. Balto. Md.	



E-363		72 06388		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		72 06388	
BIRTH NO.		STATE OF MARYLAND-DECEASED		REG. NO.					
1. NAME OF DECEASED (Type or Print) ANTIONETTE EDWARDS				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 119 E. 25th Street, Apt. 12				3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1972 10:25 A.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 806			
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 3-30-57		10. AGE (In years last birthday) 15		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 1708 E. Federal Street	
13. BIRTHPLACE (State or foreign country) Balto. Md.		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME Toney Edwards		16. MOTHER'S MAIDEN NAME Leavon + Pearson			
17. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		18. KIND OF BUSINESS OR INDUSTRY None		19. SOCIAL SECURITY NO. —		20. INFORMANT Leavon + Edwards		ADDRESS Same	
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		22. SOCIAL SECURITY NO. —		23. INFORMANT Leavon + Edwards		ADDRESS Same			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of Neck				CAUSE OF DEATH Gunshot wound of Neck		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION 7-5-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 119 E. 25th Street					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-5-72 10:15 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Unknown					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/5/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-72		24C. NAME OF CEMETERY or CREMATORY MT. Auburn, Md.		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Audrey H. Hinton		25C. FUNERAL DIRECTOR Elmer D. Wilson		ADDRESS 1000 Brantley Ave.			

VALLEY FORD

VALLEY FORD

VALLEY FORD

VALLEY FORD

VALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400 72 06389		BALTIMORE CITY HEALTH DEPARTMENT		72 06389
STATE OF MARYLAND-DEMH		CERTIFICATE OF DEATH		REG. NO. _____
BIRTH NO. <u>01ive C Reiley Hill</u>		2. DATE AND HOUR OF DEATH <u>July 9, 1972</u> <u>1:30 A.M.</u>		
1. NAME OF DECEASED (Type or Print) <u>OLIVE HILL</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>39 PROVIDENT HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1548</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>		6. RACE <u>B</u>		E. STREET AND NUMBER <u>HILTON NURSING HOME-POPLAR ST.</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-91</u>		9. AGE (In years last birthday) <u>91 yrs</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William</u>		14. MOTHER'S MAIDEN NAME <u>Sarah</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>W. A. RICHARDSON SR.</u> ADDRESS <u>3702 1/2 Clifton Avenue</u>
18. <u>7-10-91</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>Possible Acute Myocardial Infarction</u>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Generalized Arteriosclerosis Magna et fort</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>July 8</u> 19 <u>72</u> to <u>July 9</u> 19 <u>72</u>		
that (I) (we) lost saw the deceased alive on <u>July 9</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Virginia F. Mercado</u> DEGREE		
23B. DATE SIGNED <u>7/9/72</u>		23C. PHYSICIAN'S NAME (Type) <u>VIRGINIA F. MERCADO</u> DEGREE		
23D. ADDRESS <u>Provident Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>7/14/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Maryland National Park</u>		
24D. LOCATION (City, town, or county) <u>Washington Blvd Laurel Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>		
25B. NAME OF REGISTRAR <u>Adolphus Halstead</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Adolphus Halstead 1206 W north Ave</u>		

7/7/70

3702 Clifton ave.

BIRTH NO.		STATE OF MARYLAND		72 06391		BALTIMORE CITY HEALTH DEPARTMENT		72 06391	
1. NAME OF DECEASED (Type or Print)						2. DATE OF DEATH			
Noreen Gordon						Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION						3. DATE PRONOUNCED DEAD			
(If not in hospital or institution, give street address or location)						Month Day Year Hour			
St. Agnes Hospital						7 6 72 10:05 P. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						A. STATE B. COUNTY			
Maryland Howard						6300			
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Ellicott City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Nov. 12, 1929		42		Maryland		U.S.A.		Joseph Harden (deceased)	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						15. MOTHER'S MAIDEN NAME			
House Wife						Maud Gerflinger (deceased)			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)						17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
No						215-24-1504		Joseph Gordon, Sr. 4942 Orchard Drive Ellicott City, Md. 21203	
19. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)						Subarachnoid Hemorrhage			
DUE TO, OR AS A CONSEQUENCE OF:						(B)			
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OF THE
COUNTY OF
JULY 1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-416 72 06390		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06390	
BIRTH NO. STATE OF MARYLAND-DEMD							
1. NAME OF DECEASED (Type or Print) <u>Belfer, James</u>				2. DATE AND HOUR OF DEATH <u>7/7/72</u> <u>8:55 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>402</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bolton Hill Nursing Home</u> <u>90</u>				C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>312 N. Pearl Street</u>			
5. SEX <u>M</u>	6. RACE <u>Blk</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-97</u>	9. AGE (In years last birthday) <u>75 yrs.</u>	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>231-03-1210</u>				17. INFORMANT <u>Unknown</u>			
18. <u>412-31</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>arteriosclerosis generalized</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>6/30</u> 19 <u>72</u> to <u>7/7</u> 19 <u>72</u> that (1) (we) lost saw the deceased alive on <u>7/7</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>7/10/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MARCH MD</u>				23D. ADDRESS <u>2 E Red St Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7/15/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Forest City</u>		24D. LOCATION (City, town, or county) (State) <u>North Carolina</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>				25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead 1206 W North Ave</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 06392</u>
B-435		12 06392		72 06392
CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>Baldinger, Winfred</u> Helen		2. DATE AND HOUR OF DEATH <u>7/7/72</u> - <u>9³⁵ a.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2834</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>903 Nottingham Road Apt. 4B</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/87</u>	9. AGE (In years last birthday) <u>85</u> If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Late Joseph Zeller</u>		
14. MOTHER'S MAIDEN NAME <u>Late Mary</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>215-50-9376</u>		17. INFORMANT <u>Fred sheet of the Hosp. Edmondson</u> ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Resp. failure and aspiration</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac arrest on 6/2/72</u> (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cholecystitis 5/30/72</u>				
19A. DATE OF OPERATION <u>5/30/72</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Acute cholecystitis</u>	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>May 24</u> 19 <u>72</u> to <u>July 7</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>V. R. Felipa M.D.</u>		23B. DATE SIGNED <u>7/7/72</u>		23C. PHYSICIAN'S NAME (Type) <u>V. R. FELIPA</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/10/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>		
25B. NAME OF REGISTRAR <u>Adrian Wharton</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue</u>		
25D. ADDRESS <u>21228</u>				

1972 JAN 24

28

13/2/72
CNC

21-22-72

72 66393 BALTIMORE CITY HEALTH DEPARTMENT 72 66393

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEMD

BIRTH NO. _____ REG. NO. _____

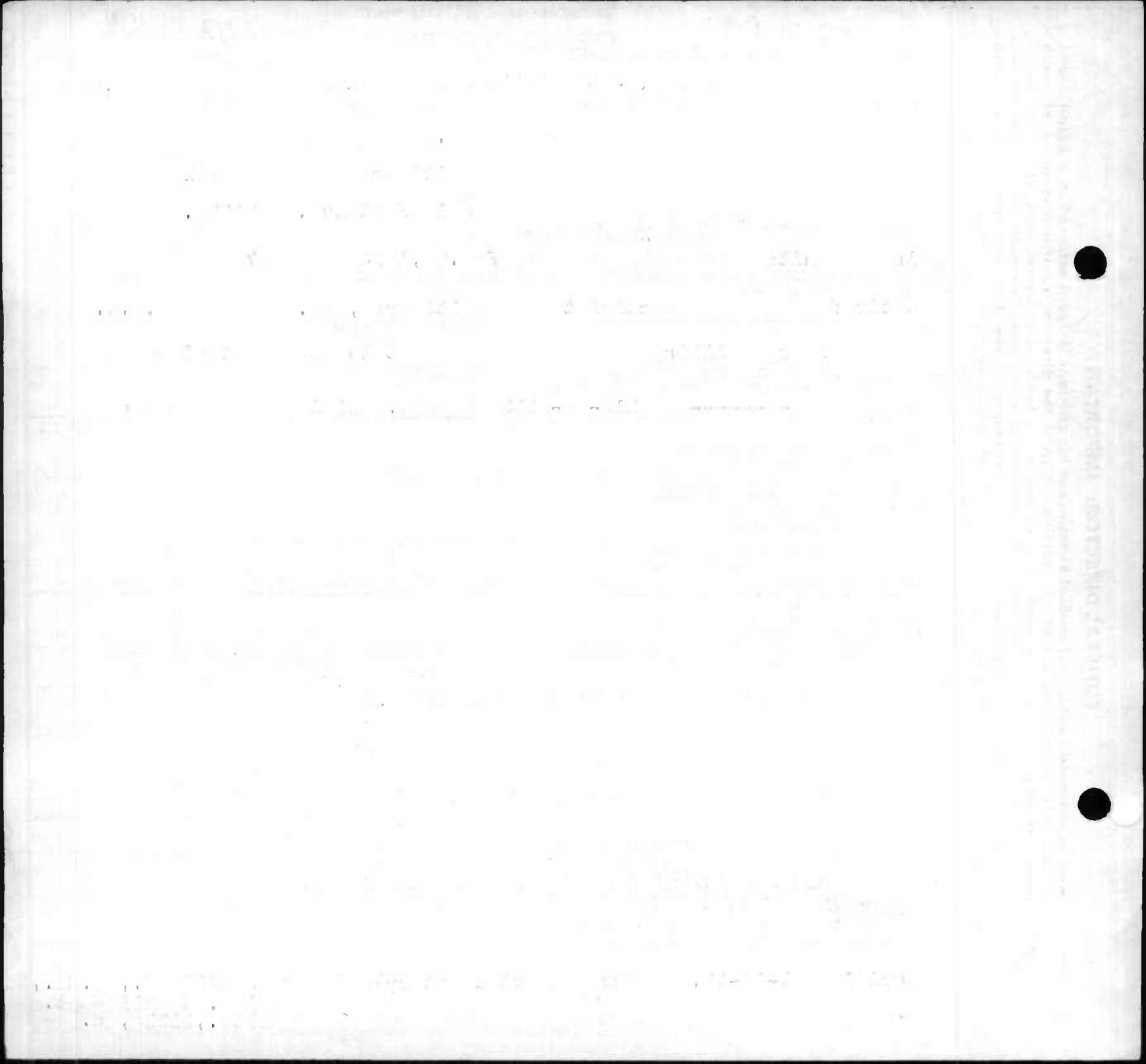
1. NAME OF DECEASED (Type or Print) Ollie Sideberry		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 7 72 8:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 7 72 8:00 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1802	
9. DATE OF BIRTH June 14, 1925		10. AGE (In years last birthday) 47	
11. BIRTHPLACE (State or foreign country) Spartenburg, S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT Willie Mae Garey		ADDRESS 1405 Carswell St.	
19. 5718 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W.P. Mulloy M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) William P. Mulloy, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-7-72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 11, 72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Lewis T Gwynn	
25C. FUNERAL DIRECTOR Lewis T Gwynn		ADDRESS 4517 Park Heights Ave.	

VS 151-REV. 7/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 06394				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06394	
STATE OF MARYLAND-DEPT				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John Billing (JOHN BILLING)				2. DATE AND HOUR OF DEATH 7-8-72 8:10 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2609			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Feb. 20, 1894		9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George Billing			
14. MOTHER'S MAIDEN NAME Catherine Poetzel				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 215-05-5223				17. INFORMANT Emma E. Billing			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (1) (this hospital) attended the deceased from 7-6-72 to 7-8-72 that (1) (we) last saw the deceased alive on 7-8-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. 23A. SIGNATURE (Signature) 23B. DATE SIGNED 23C. PHYSICIAN'S NAME (Type) (Signature) 23D. ADDRESS (Signature) 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 7-11-72 24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery 24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Ba. Co., Md. 25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972 25B. NAME OF REGISTRAR Sidney Weston 25C. FUNERAL DIRECTOR Charles S. Seiler ADDRESS 901 S. Conkling St. Balto., 21224, Md.							



72 06395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 06395

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

STATE OF MARYLAND - DEATH

SCHATZ, ROSE, C.

2. DATE AND HOUR OF DEATH

7-6-72

10:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3301 FLEET ST.

21224

5. SEX

FEMALE

6. RACE

Caucasian

WHITE

7. MARRIED

NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

12-5-94

9. AGE (In years
last birthday)

77

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

HOUSE WORK

11. BIRTHPLACE (State or foreign country)

BALTIMORE
MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES YOUNG

14. MOTHER'S MAIDEN NAME

MARY ROBINSON

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

212-12-4476A

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH: RECORDS Baltimore, Maryland 21224

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Brainstem CVA

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/2 19 72 to 7/6 19 72
that (I) (we) last saw the deceased alive on 7/6 19 72 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Matthew N. Fine M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/6/72

23C. PHYSICIAN'S
NAME (Type)

Matthew N. Fine, M.D.

23D. ADDRESS

Baltimore City Hospitals

21224

DEGREE

4940 Eastern Avenue Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

7-10-72

24C. NAME OF CEMETERY or CREMATORY

SACRED HEART CEM.

24D. LOCATION

(City, town, or county)

(State)

7401 GERMAN HILL RD. BA. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.

JUN 10 1972

25B. NAME OF REGISTRAR

Sidney H. Houston

25C. FUNERAL DIRECTOR

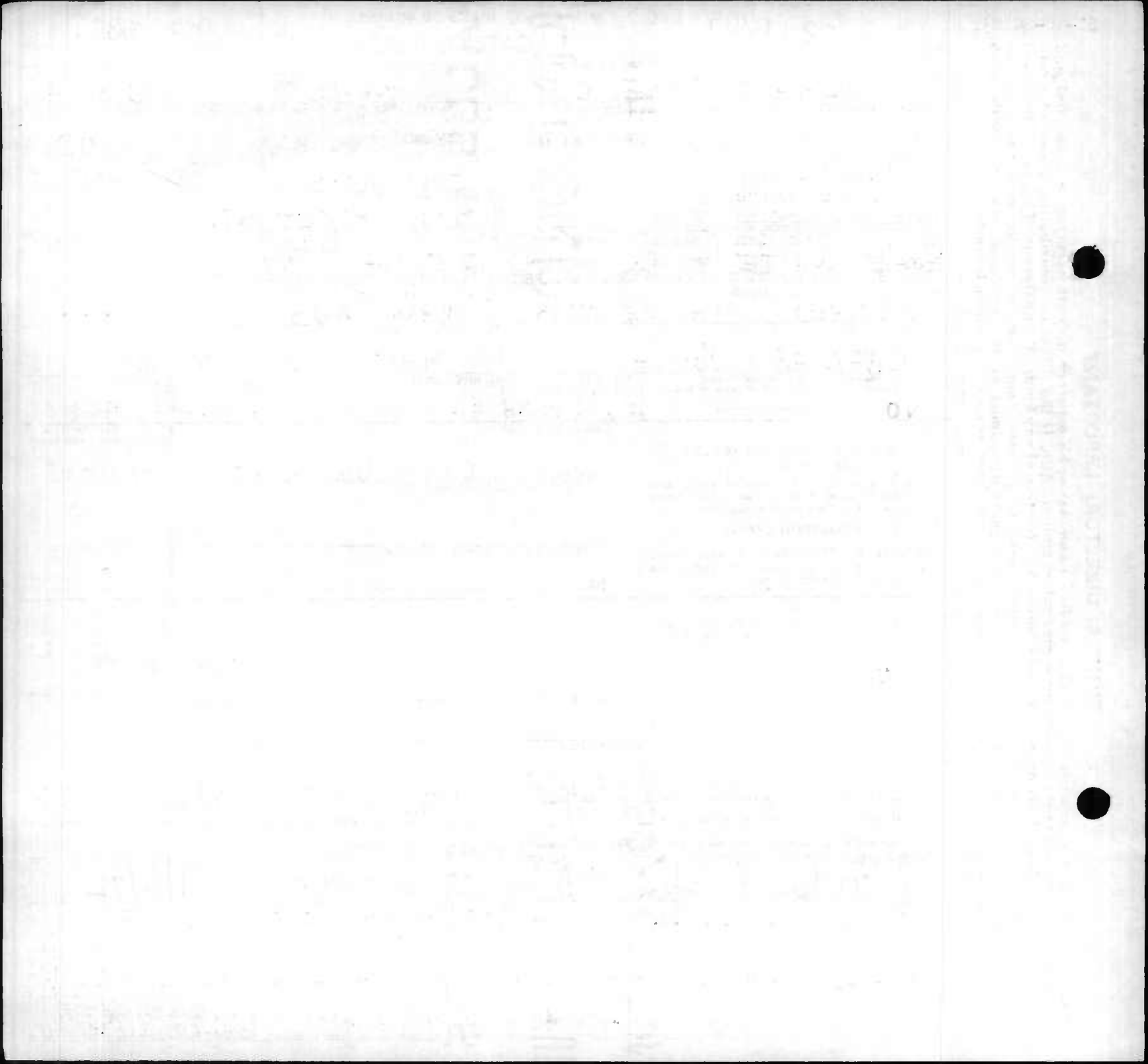
Charles S. Jailer

ADDRESS

901 S. CONKLING ST.
BALTO., 21224, MD.

FUNERAL DIRECTOR: IMPORTANT

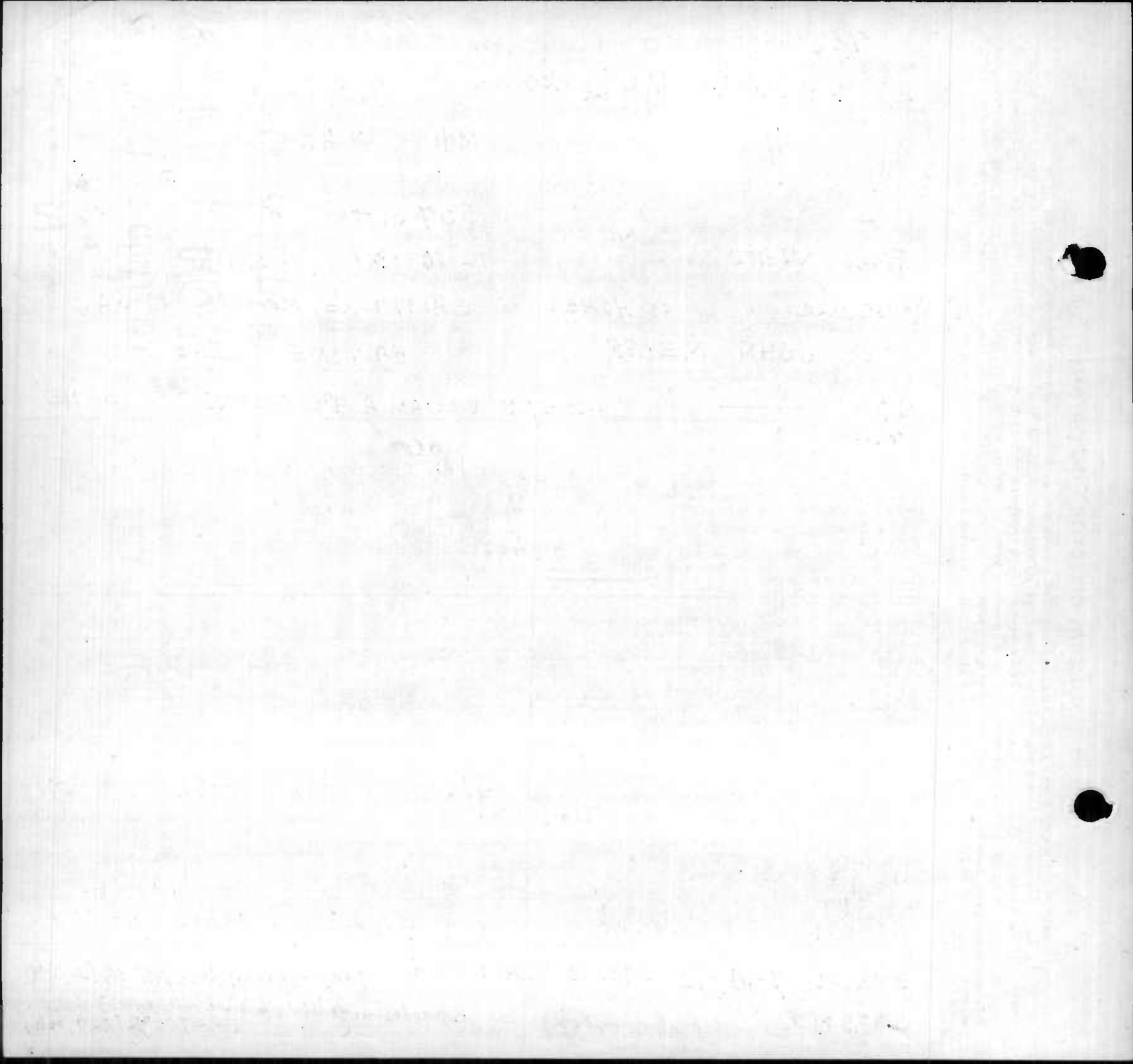
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
72 06396 STATE OF MARYLAND					REG. NO. 72 06396					
BIRTH NO. 72 06396					CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Elizabeth Mc Lelland					2. DATE AND HOUR OF DEATH 7/6/72 3:20 P. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp 43					A. STATE Md. Baltimore					
					C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
					E. STREET AND NUMBER 537 S. 48th St.					
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-1889		9. AGE (In years lost birthday) 82		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY AT HOME.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MEYER					14. MOTHER'S MAIDEN NAME PAULINE CLEAR					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 214-20-5753		17. INFORMANT WILLIAM A. McCLELLAND		ADDRESS SAME.	
18. CAUSE OF DEATH										
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(B) ASCUTED					
ANTECEDENT CAUSES					(C) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).										
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/6 1972 to 7/6 1972, that (I) (we) last saw the deceased alive on 7/6/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE [Signature]					OEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/6/72			
23C. PHYSICIAN'S NAME (Type) GEORGE DANDRINO					23D. ADDRESS 5113 Eastern Ave. Balt MD 21214					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-10-72		24C. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		24D. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., BA. CO., MD.				
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972			25B. NAME OF REGISTRAR Sidney W. Weston			25C. FUNERAL DIRECTOR Charles S. Jellor 6224 EASTERN AVE. BALTO., 21224, MD.				



G-530

72 06397

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06397

BIRTH STATE OF MARYLAND-DEATH

REG. NO.

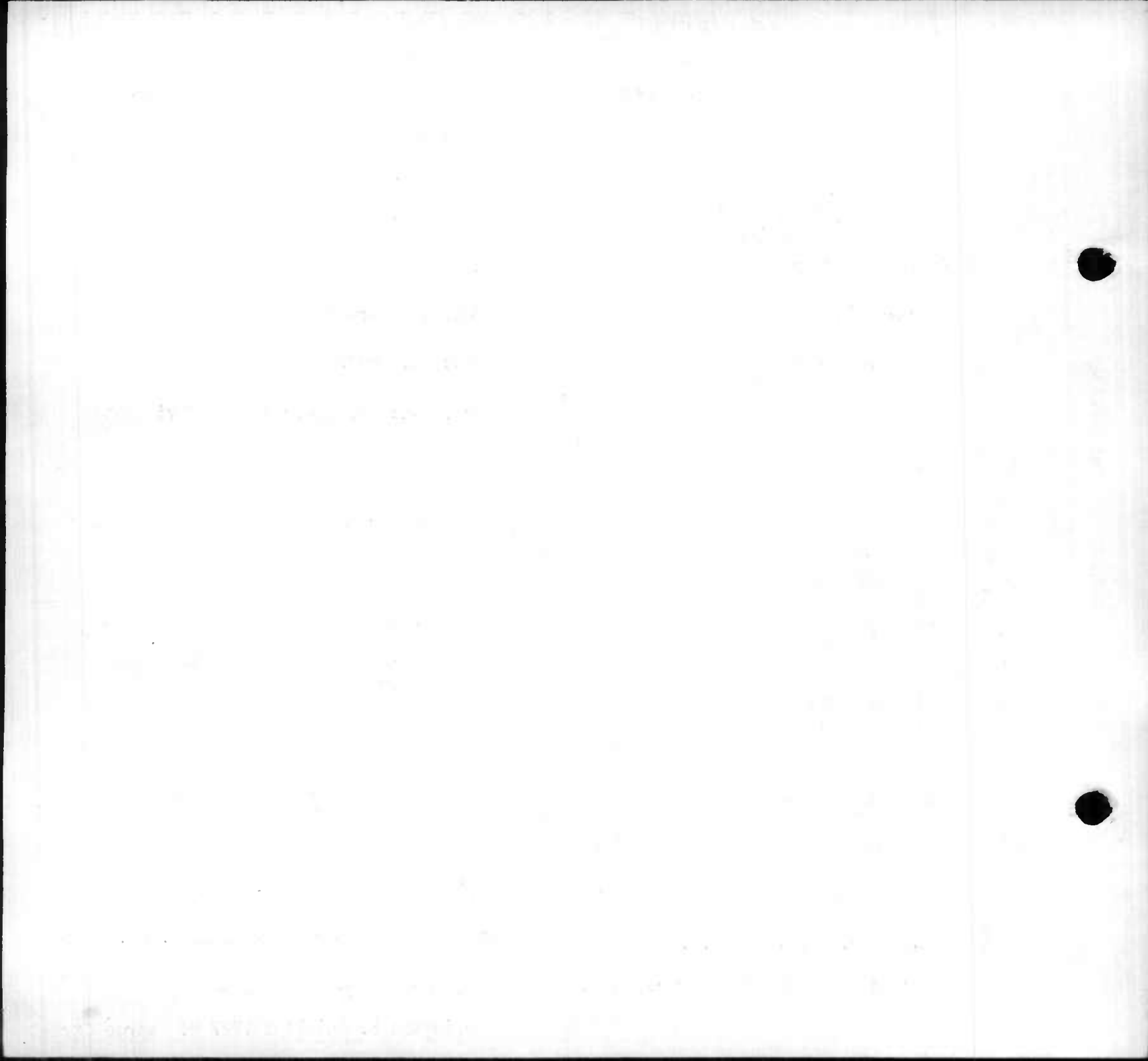
1. NAME OF DECEASED (Type or Print) Gary Gant		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 7 72 5:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 7 72 5:00 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEP DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Sept. 20, 1950		10. AGE (in years lost birthday) 21	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Gant		14. MOTHER'S MAIDEN NAME Juanita White	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security Guard		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes	
17. SOCIAL SECURITY NO. 217-52-6149		18. INFORMANT ADDRESS Mrs. Juanita Gant 3003 Westwood Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7-11-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 755 W. Lexington Street		22F. HOW DID INJURY OCCUR? stabbed during altercation	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 7 5 72 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W P Mulloy EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7-7-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) A. A. Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Sidney Johnson	
25C. FUNERAL DIRECTOR Arlington S. Phillips		25D. ADDRESS 1727 N. Monroe Street	

ACADEMIC RECORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-240 72 66398		BALTIMORE CITY HEALTH DEPARTMENT		72 66398	
BIRTH NO. STATE OF MARYLAND-DHMH				REG. NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Roberta Ashley			July 4, 1972		8:45 A. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			A. STATE B. COUNTY		
46 Lutheran Hospital Baltimore, Maryland			Maryland		
5. SEX Female			6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH Dec. 8, 1918			9. AGE (In years last birthday) 53		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) McDean, Georgia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jessie Ashley			14. MOTHER'S MAIDEN NAME Nancy E. Scott		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Nancy E. Roberts 921 Kevin Road
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Pulmonary embolus or arrhythmia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rheumatic heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden 30 yrs 6 yrs		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1967 to 7/4 1972 that (I) (we) last saw the deceased alive on 6/28 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis H. Schaffer, M.D.			23B. DATE SIGNED 7/6/72		23C. PHYSICIAN'S NAME (Type) Louis H. Schaffer, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial			7-8-72		Maryland National Mem. Park Laurel, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972			25B. NAME OF REGISTRAR Dorothy Johnson		25C. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monroe Street



7-630

72 06399

BALTIMORE CITY HEALTH DEPARTMENT

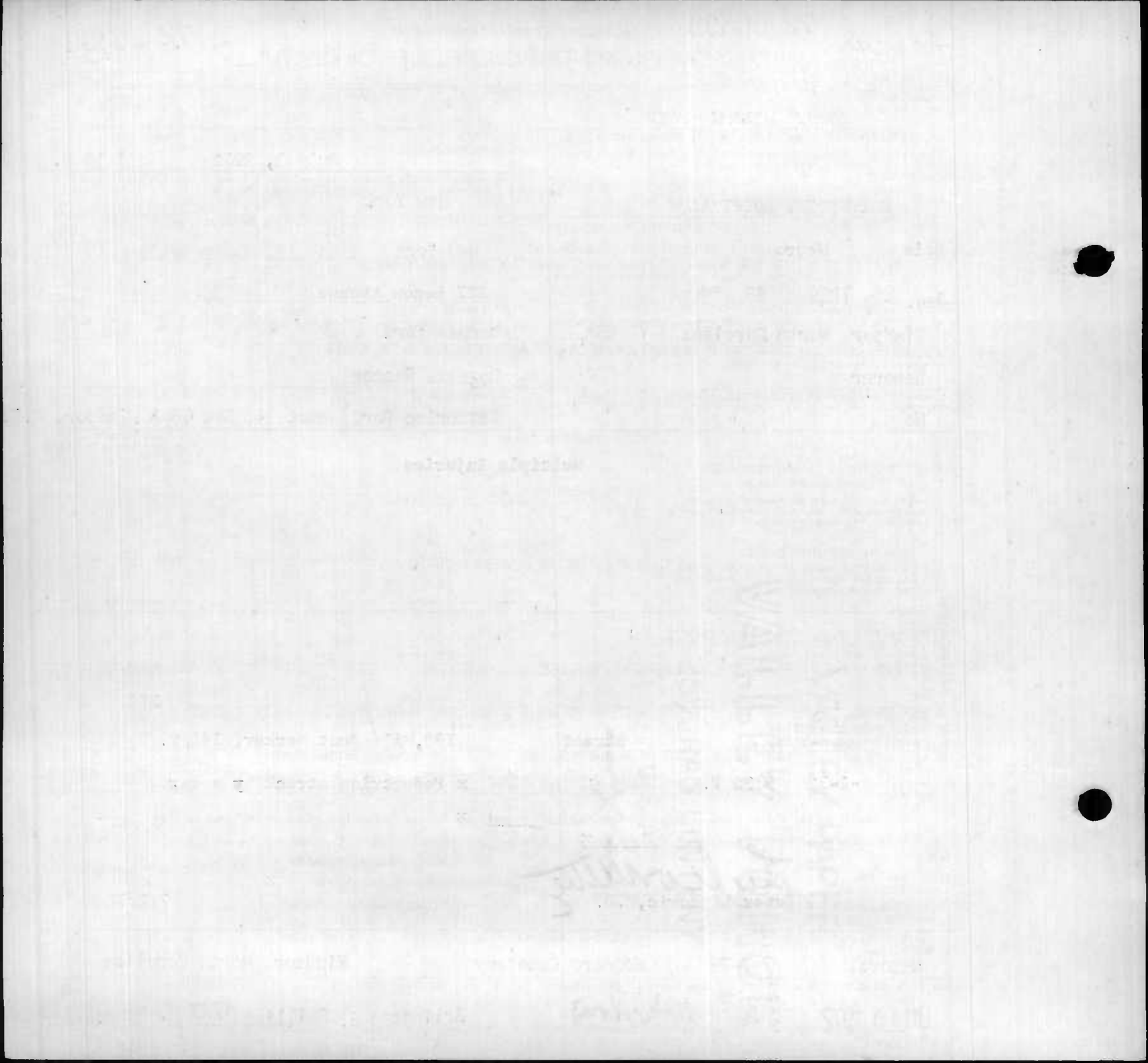
72 06399

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. STATE OF MARYLAND-DEATH

1. NAME OF DECEASED (Type or Print) BUDDY WILSON FORD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour July 1, 1972 11:10 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE New York B. COUNTY V29			
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN New York
9. DATE OF BIRTH Jan 29, 1929		10. AGE (In years lost birthday) 43	E. STREET AND NUMBER 527 Lenox Avenue
11. BIRTHPLACE (State or foreign country) Windsor, North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Norman Ford
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Rozetta Rascoe
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS Catherine Ford Route 4, Box 15 A Windsor, N.C.
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 195 Mile Post Marker, 161 S.		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 7-1-72 9:30 P.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by a car	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/2/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7-7-72	
24C. NAME OF CEMETERY or CREMATORY Woodard Cemetery		24D. LOCATION (City, town, or county) (State) Windsor, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Sidney Winston	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe Street	



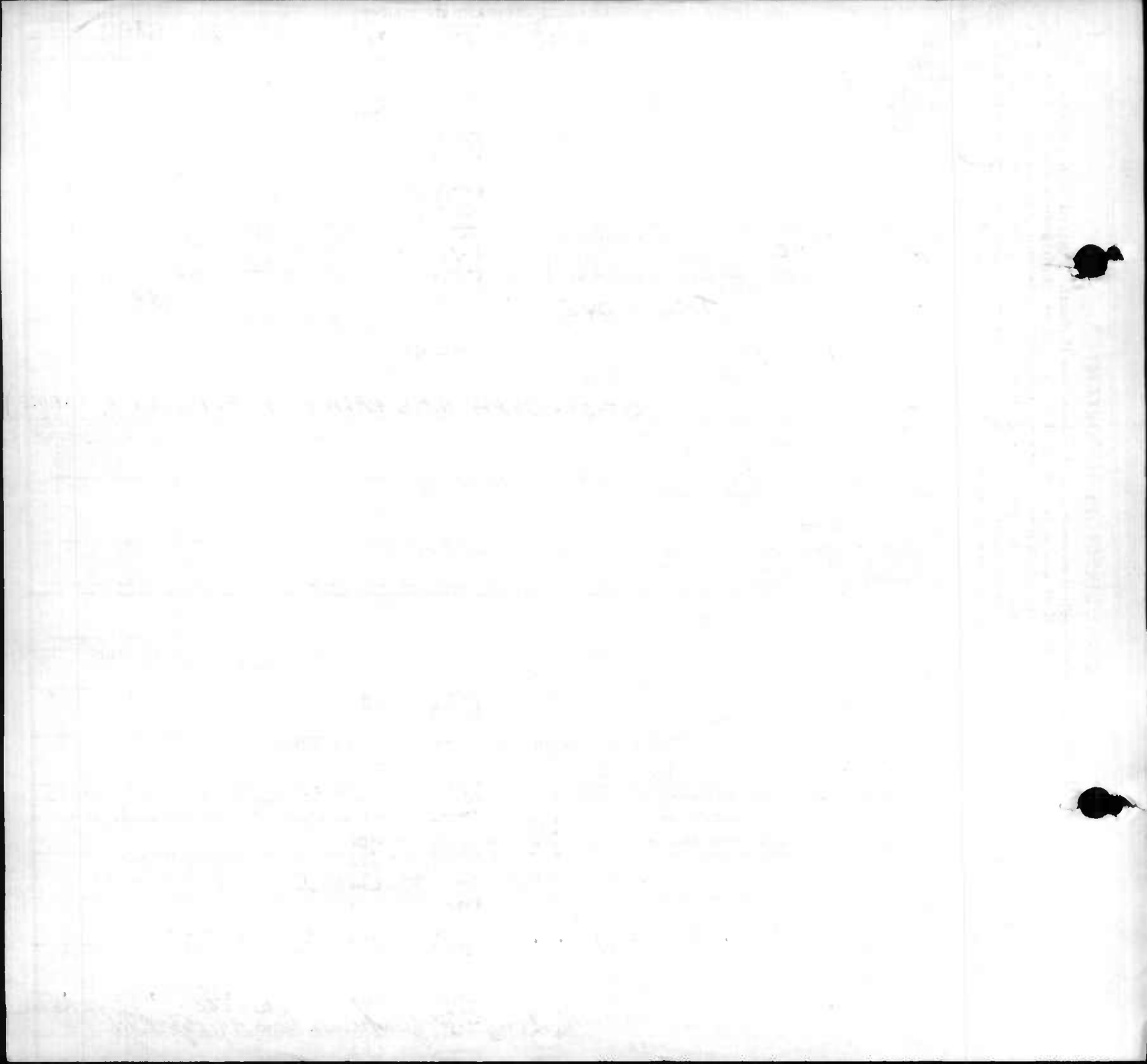
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 72 06400

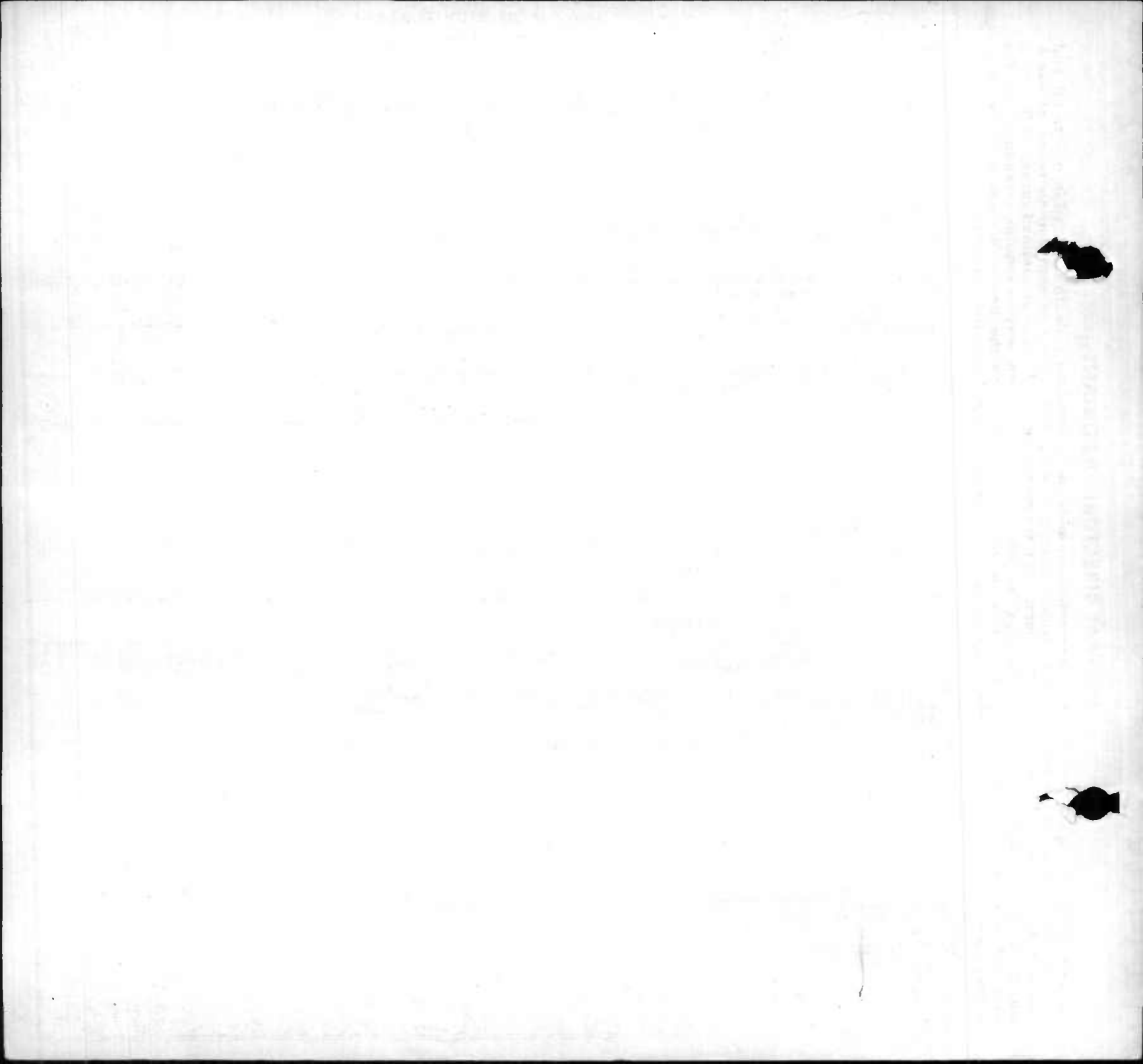
BIRTH NO. 72 06400		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) FRANK B. MILLER		2. DATE AND HOUR OF DEATH 8 JULY 1972 4:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 44		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 700 E. 36th ST.	
5. SEX M	6. RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-02 9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10B. KIND OF BUSINESS OR INDUSTRY TOOL & DYE	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES R. MILLER	
14. MOTHER'S MAIDEN NAME ALMIRA KEMP		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 215-03-3748A		17. INFORMANT ADDRESS MRS. RAYMOND F. MILLER (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19A. DATE OF OPERATION 23 JUNE 1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ISCHEMIC NEUROPSIS PENIS	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (mostly medical examined) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) N/A	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> N/A		21F. HOW DID INJURY OCCUR? N/A	
22. I certify that (H) (this hospital) attended the deceased from 15 June 1972 to 8 July 1972 that (H) (we) last saw the deceased alive on 8 July 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Neil O. Thompson, M.D.		23B. DATE SIGNED 8 July 72	
23C. PHYSICIAN'S NAME (Type) Neil O. Thompson, M.D.		23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/72	
24C. NAME OF CEMETERY OR CREMATORY Oaklawn		24D. LOCATION Baltimore County Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Sidney W. Horton	
25C. FUNERAL DIRECTOR H.W. Jenkins		25D. ADDRESS 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

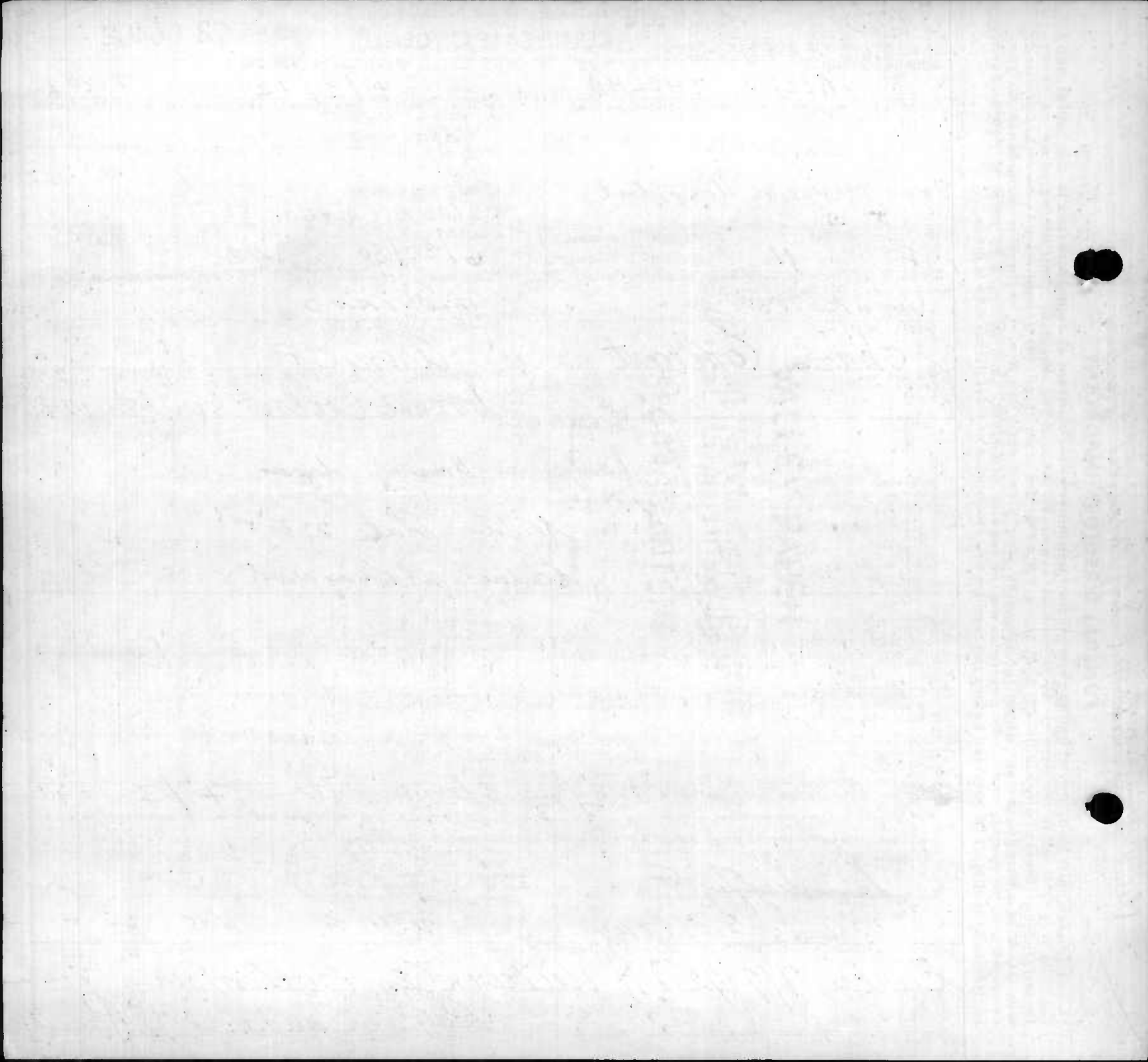
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 06401</u>	
P-623 72 06401		BIRTH NO. STATE OF <u>MARYLAND-DEMH</u>	
1. NAME OF DECEASED (Type or Print) <u>PROCTOR, WILLIAM</u>		2. DATE AND HOUR OF DEATH <u>7-2-1972</u> <u>5.30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Union Memorial Hospital</u> <u>44</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1204</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>407 HEAVER street</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/20/18</u> 9. AGE (In years lost birthday) <u>53</u> 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Thomas</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Myrtle Proctor wife</u>		ADDRESS	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypovolemic shock</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Hemorrhage, gum</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) <u>NO?</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 1st.</u> 19 <u>72</u> to <u>July 2nd</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>July 2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Luis Sirotzky</u>		23B. DATE SIGNED <u>July 2, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>LUIS SIROTZKY</u>		23D. ADDRESS <u>U. M. H.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-6-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Edgar Hill Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>A.A. Co Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>		25B. NAME OF REGISTRAR <u>Rayner Sanders</u>	
25C. FUNERAL DIRECTOR <u>217 E. Preston St</u>		ADDRESS	



(Per Telegraph) Requested by Medical Examiner
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

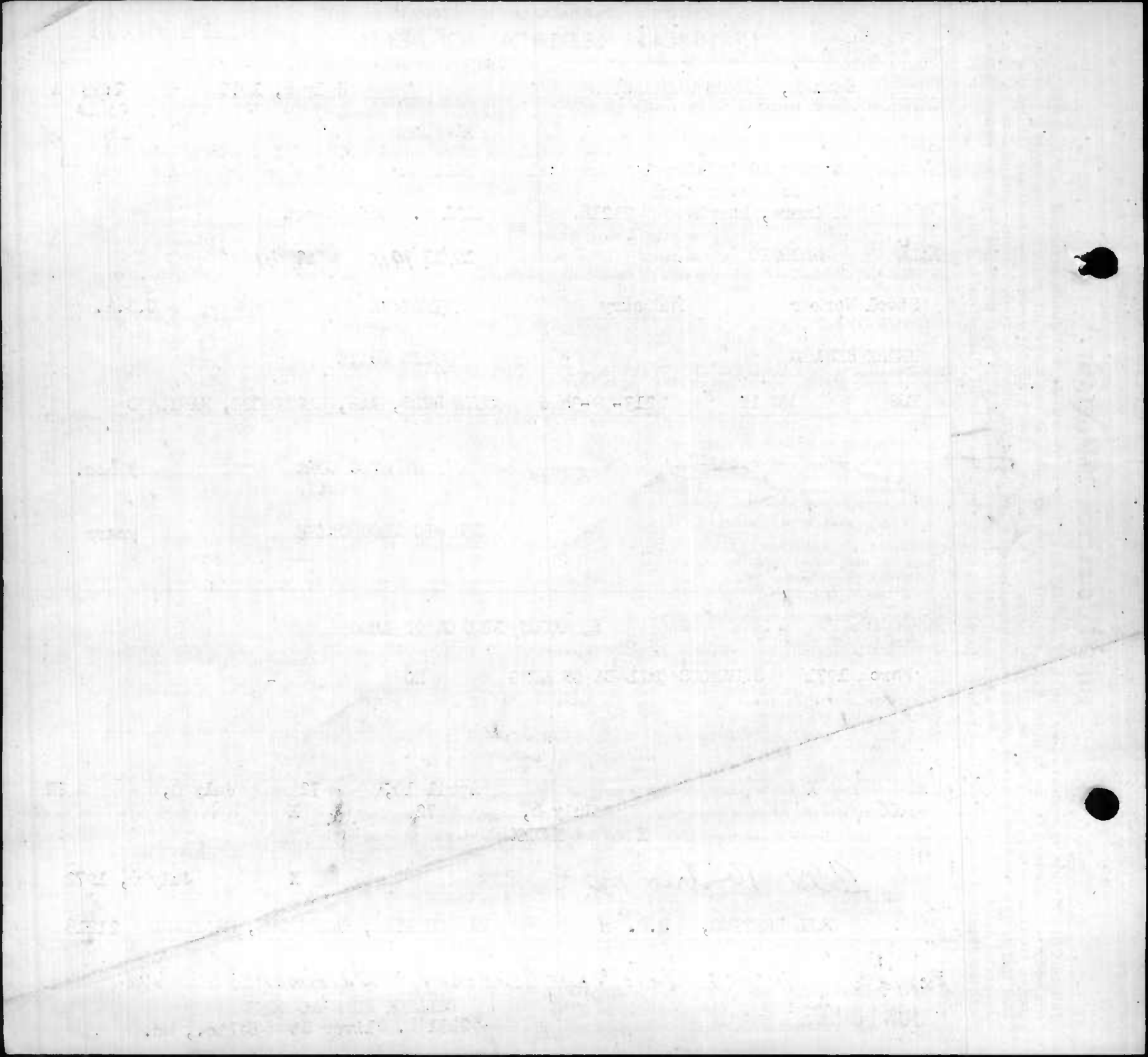
A 450		72 06402		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06402	
BIRTH NO. STATE OF MARYLAND-DEMD		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		ALLEN, THELMA		2. DATE AND HOUR OF DEATH 7/3/72		7:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE MARYLAND		B. COUNTY 1204	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2106 N. CALVERT ST		5. SEX F		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/30/30		9. AGE (In years last birthday) 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Charles Colbert		14. MOTHER'S MAIDEN NAME Annie P.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Donald Colbert		ADDRESS 5000 Denver Ed	
18. 427.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, such as heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, rising to the above cause UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anomalous Septic (B) Secondary Septic DUE TO, OR AS A CONSEQUENCE OF: (C) Cardiac - pulmonary arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/30/72 to 7/3/72, that (I) (we) last saw the deceased alive on 7/3/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Louis Sirotzky		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) Louis Sirotzky		23D. ADDRESS 2106 N. CALVERT ST.		23E. MED. DIRECTOR H. S.		23F. STAFF PHYS. H. S.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Baltimore		24D. LOCATION (City, town, or county) (State) Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972		25B. NAME OF REGISTRAR Ragner Sanders		25C. FUNERAL DIRECTOR Ragner Sanders		25D. ADDRESS 217 E. Preston	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06403	
<div style="display: flex; justify-content: space-between;"> S-630 72 06403 72 06403 </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. STATE OF MARYLAND-DHMH 1. NAME OF DECEASED <small>(Type or Print)</small> SEWARD, GEORGE WASHINGTON </div> <div> 2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> July 6, 1972 2:45 A. M. </div> </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218 </div> <div> 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> MARYLAND 808 </div> </div> </div>			5. CITY OR TOWN BALTIMORE		
6. STREET AND NUMBER 1131 N. Bond Street			7. INSIDE CITY LIMITS? <div style="display: flex; justify-content: space-between;"> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </div>		
8. SEX MALE		9. RACE NEGROID		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
11. DATE OF BIRTH 10/13/1910		12. AGE (In years last birthday) M 61		13. If Under 1 Yr. Months: Days: 14. If Under 24 Hrs. Hours: Min.	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		16. KIND OF BUSINESS OR INDUSTRY Industry		17. BIRTHPLACE (State or foreign country) VIRGINIA	
18. CITIZEN OF WHAT COUNTRY? U.S.A.		19. FATHER'S NAME HENRY SEWARD			
20. MOTHER'S MAIDEN NAME SUSIE WHITE		21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II			
22. SOCIAL SECURITY NO. 213-09-3446		23. INFORMANT CLIN RCDS, BAH, BALTIMORE, MARYLAND			
24. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</small> 303.21-162.1 </div> <div> (A) IMMEDIATE CAUSE HEPATIC COMA DUE TO, OR AS A CONSEQUENCE OF: </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div> 25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (B) CHRONIC ALCOHOLISM DUE TO, OR AS A CONSEQUENCE OF: </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div> (C) </div> <div> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos. </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). SQUAMOUS CELL CA OF LUNG					
19A. DATE OF OPERATION March 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SQUAMOUS CELL CA OF LUNG		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED <div style="display: flex; justify-content: space-between;"> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </div>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 10, 19 72 to July 6, 19 72 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 6, 19 72 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carl Restivo M.D.				23B. DATE SIGNED July 6, 1972	
23C. PHYSICIAN'S NAME (Type) CARL RESTIVO, M.D.				23D. ADDRESS VA HOSPITAL, BALTIMORE, MARYLAND 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-72		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972			
25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR COLLICK FUNERAL HOME 2431 E. Oliver St Balto., Md.			



G-650

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. STATE OF MARYLAND - DEATH

REG. NO.

1. NAME OF DECEASED (Type or Print) Doxie P. Green		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 7 7 72 10:10A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5200 Gwynn Oak Avenue		3. DATE PRONOUNCED DEAD Month Day Year 7 7 72 10:10A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-17-86		10. AGE (In years last birthday) 85	
11. BIRTHPLACE (State or foreign country) Warrington Co, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unk.		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2802	
15. MOTHER'S MAIDEN NAME Angeline		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes # 1	
17. SOCIAL SECURITY NO. 215-18-5240		18. INFORMANT Mrs. Goldie Bey 5200 Gwynn Oak Ave. 21207	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7-7-72		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 7-12-1972		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk,	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1972	
25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr., 1735 Harford Ave. 21213	

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

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10-17-62

U.S.A.

Department of the Army

Attorney General

Director

Department of the Army

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Department of the Army

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 66405</u>	
T-600 72 66405				CERTIFICATE OF DEATH	
BIRTH NO. <u>STATE OF MARYLAND-Demo</u>		1. NAME OF DECEASED (Type or Print) <u>QUINCY TERRY</u>			
2. DATE AND HOUR OF DEATH <u>JULY 6, 1972</u> <u>6:45 A.</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital</u> <u>43</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>806</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1622 N. Wolfe St</u>			
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1908</u>	9. AGE in years last birthday <u>64</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Rockingham, N. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>William Terry</u>			14. MOTHER'S MAIDEN NAME <u>Nannie Cole</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mr. Clifton Terry 1622 N. Wolfe St. 21213</u>	
18. <u>431914-2509</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRO-VASCULAR HEMORRAGE 8 DAYS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARTERIOSCLEROSIS</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>DIABETES MELLITUS</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 18, 1972</u> to <u>July 6, 1972</u> , that (I) <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 6, 1972</u> and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Julius Toshoff, M.D.</u> DEGREE				23B. DATE SIGNED <u>July 6, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>JULIUS G. TOSHOFF, M.D.</u> DEGREE				23D. ADDRESS <u>2085 Woodbourne Ave, Baltimore, Md. 21239</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-10-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Winston</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Marshall W. Jones, Jr. 1735 Harford Ave. 21213</u>	

7

3-13-1908 PM

Reception, N. Carolina

Reception

Reception

Reception

Reception

Mr. William Henry Jones, N. Carolina

no

Reception, N. Carolina

Reception

Reception

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPT. OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06406	
BIRTH NO. 72 06406				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) PLITT, BABY BOY			2. DATE AND HOUR OF DEATH JULY 7, 1972 4:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 21227 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 4757 ALDGA TE GREEN 5300		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/06/72	9. AGE (In years last birthday) 18	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THOMAS PLITT			14. MOTHER'S MAIDEN NAME PATRICIA PLUSCHKELL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT BALTO MD 21229 ADDRESS ST AGNES' RECORDS CATON & WILKENS AVES
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 772.01 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) Immaturity DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 2/1 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR? _____			21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		
22. I certify that MM (this hospital) attended the deceased from JULY 6 19 72 to JULY 7 19 72 , that (X) (we) last saw the deceased alive on JULY 7 19 72 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) view the body after death.					
23A. SIGNATURE Kusuma Pruksapong M.D.			23B. DATE SIGNED 4/7/72		23C. PHYSICIAN'S NAME (Type) KUSUMA PRUKSAPONG M.D.
23D. ADDRESS St. Agnes Hosp. Balto. Md. 21229			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7-8-1972			24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		
25B. NAME OF REGISTRAR Sidney Hubbard			25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		

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JULY 7, 1957

CLINT, PAUL Y. BOY

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06407	
BIRTH NO. 72 06407		CERTIFICATE OF DEATH		REG. NO. 72 06407	
1. NAME OF DECEASED (Type or Print) Mrs. Howland Evagannett			2. DATE AND HOUR OF DEATH 7/7/72 5-30 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital 481			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1214, Euton Pl. Key Green					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/89	9. AGE (in years lost birthday) 89 yrs.	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? American					
13. FATHER'S NAME Charles Wesley Green			14. MOTHER'S MAIDEN NAME Cecelia White		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO.		17. INFORMANT Charles C. Green Catonsville, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Renal failure DUE TO, OR AS A CONSEQUENCE OF: (B) Dehydration, Urinary Tract Infection DUE TO, OR AS A CONSEQUENCE OF: (C) Senility, Fr. Hip.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Yes		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Balt. 1214, Euton Place	
21D. TIME OF INJURY (APPROX.) 6/30/72		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pt. fell. 1702	
22. I certify that (I) (this hospital) attended the deceased from 6/30/72 1972 to 7/7/72 1972 that (I) (we) last saw the deceased alive on 7/6/72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bharat Desai			23B. DATE SIGNED 7/7/72		
23C. PHYSICIAN'S NAME (Type) BHARAT DESAI			23D. ADDRESS 5408 A, Sarrit Rd, Baltimore 21206		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/72		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Audrey Ingham		25C. FUNERAL DIRECTOR Edw. S. MacNabb Sons, Inc. 301 Frederick Rd. Catonsville, Md.	

9/18/69 - Adm.

No home Address.

OT

41-20-46 cal
W-523

CERTIFICATE OF DEATH

REG. NO. 72 06408

BIRTH NO. 72 06408		1. NAME OF DECEASED (Type or Print) Katherine (Ratie) Winslow		2. DATE AND HOUR OF DEATH 7/4/72 6 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BCH Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224			A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4940 Eastern Avenue 21224		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-1885	9. AGE (In years last birthday) 86	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-56-5821		17. INFORMANT BCH RECORDS: 4940 Eastern Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I 412.4-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE Cerebral degeneration DUE TO, OR AS A CONSEQUENCE OF: (B) ASFD, CHF, Fe b, Periph vascular Amp. BK DUE TO, OR AS A CONSEQUENCE OF: (C) UTE CBS, Pneumonia II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from January 22, 19 71 to July 4, 19 72, that (XX) we last saw the deceased alive on July 4, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter Dorsen				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Peter Dorsen, M.D.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-72		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel	
24D. LOCATION Balto.		24E. (City, town, or county) Md.		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Andrew W. Horton		25C. FUNERAL DIRECTOR Helma A. Hoffmann 3218 Hudson St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Adm. 1/22/71

No Prev. Address

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 67-23170

1. NAME OF DECEASED (Type or Print) JOHN T. BUCKLEW		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 So. Balto. Gen. Hosp.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 9 1972 10:25a M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 2404	
9. DATE OF BIRTH Nov. 21, 1967		10. AGE (In years lost birthday) 4	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Arthur E. Bucklew Jr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Melva Vettors		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Melva Bucklew ADDRESS 105 Bloomsbury St. Balto. Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E910.10 Drowning DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) swimming pool	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Riverside Park Swimming Pool		22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 7-9-72 10 a	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Accidentally drowned.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 7-10-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/72	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Audrey Indeston	
25C. FUNERAL DIRECTOR Mc Cully Funeral Homes		ADDRESS 130 E. Fort Avenue	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 72 06410	
BIRTH NO. 72 06410										CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Moore, Milton Thomas</u>					2. DATE AND HOUR OF DEATH <u>July 5, 1972</u> <u>11:35 AM</u> M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>M.D.</u> B. COUNTY <u>Wicomico</u> <u>2759</u>						
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hosp.</u>					C. CITY OR TOWN <u>Baltimore</u>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <u>4404 Marble Hill Rd, Baltimore</u>						
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1912</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator, Red MANAGER, MOTOR FREIGHT</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>M.D.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. FATHER'S NAME <u>Rodney, C. Moore</u>					14. MOTHER'S MAIDEN NAME <u>Nettie Adelia Harrington</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>782-09-9818</u>		17. INFORMANT <u>Virginia E. Moore</u>			ADDRESS <u>Same as above</u>	
18. <u>4124</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac arrhythmia</u>						
					(B) <u>Acute left Ventricular failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>and hypoxia</u>						
					(C) <u>ASCVD</u>						
II					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CVA, thrombosis of abdominal aorta</u>						
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>July 3, 1972</u> to <u>July 5, 1972</u> , that (I) (we) last saw the deceased alive on <u>July 5, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Chung-Hsien Yu</u> DEGREE								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>July 5, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHUNG-Hsien Yu</u> DEGREE								23D. ADDRESS <u>The Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/8/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Wicomico Memorial Park</u>			24D. LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1972</u>				25B. NAME OF REGISTRAR <u>Andrew Harrison</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Holloway Funeral Home, Salisbury, Maryland</u>				

Address is Balto. city
zip code 21218.

1		M-460 72 06411		BALTIMORE CITY HEALTH DEPARTMENT		72 06411	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.		STATE OF MARYLAND-DHMH		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/>	
1. NAME OF DECEASED (Type or Print)		JAMES MALLORY		3. DATE PRONOUNCED DEAD		Month Day Year Hour July 5, 1972 2:20 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
31 CITY HOSPITAL				Maryland Baltimore			
6. SEX	7. RACE	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Male	White			Edgemere Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years lost birthday)	11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER			
2-9-39	33	Virginia		7319 Waldman Avenue			
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
U.S.A.		Ellis B. Mallory		Self-employed		Painter	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT	
Annie L. Swaine		No		212-36-0318		Father: 7319 Waldman Ave. Mr. Ellis B. Mallory Balto. Md. 21219	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Asphyxia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) Aspiration of blood DUE TO, OR AS A CONSEQUENCE OF:					
		(C) Shotgun wound of larynx					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
2				yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
		street		Rear of Wells Avenue		5300	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
7-5-72 1:52 A.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Shot by assailant.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		7/5/72	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-8-72		Bel Air Memorial Gardens		Bel Air, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 11 1972		Sidney W. Houston		John J. Duda 7922 Wise Ave. Dundalk, Md.			

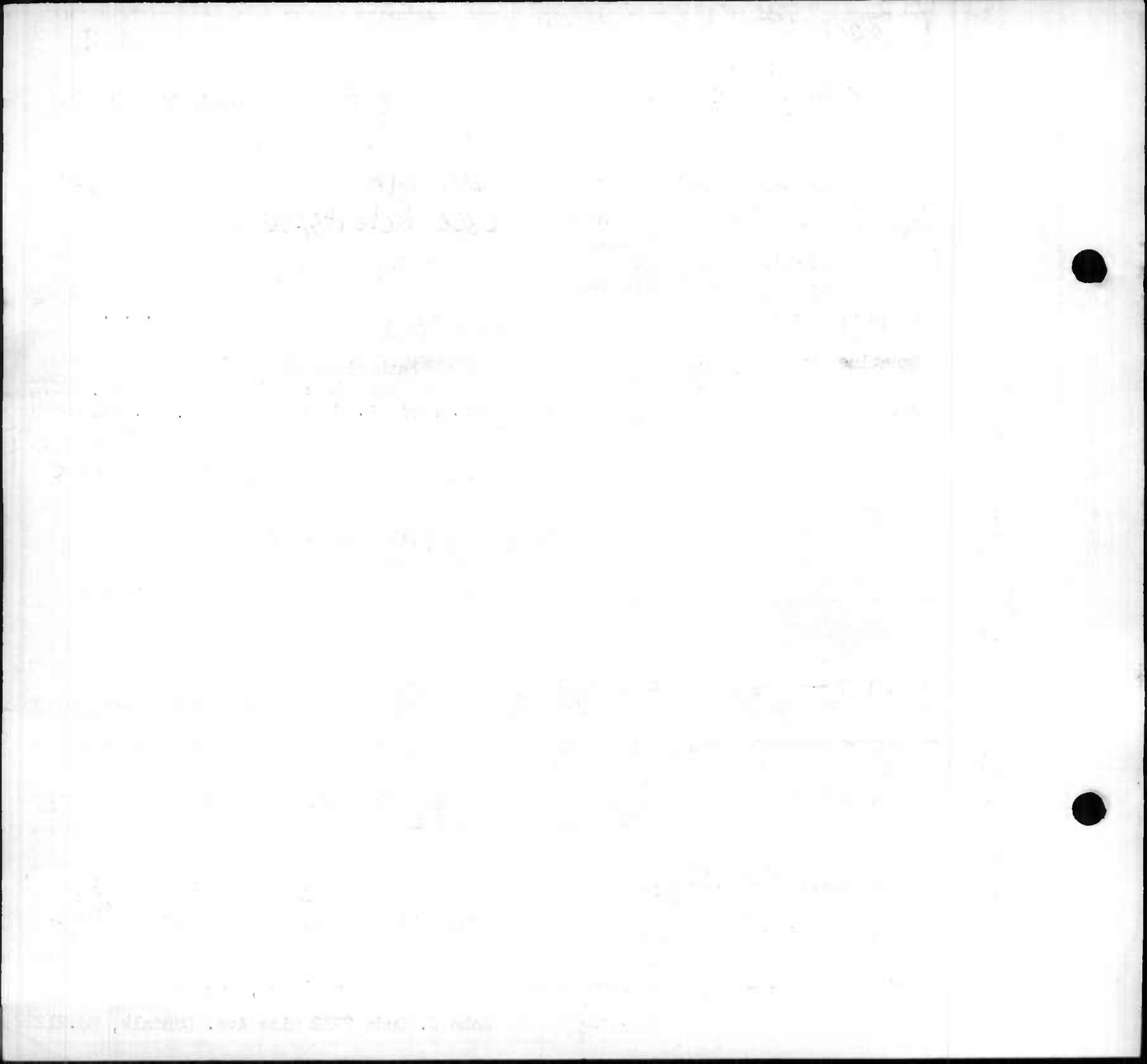
WALLACE J. BROWN

THE UNITED STATES OF AMERICA
DOCTOR OF MEDICINE
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THE UNITED STATES OF AMERICA
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

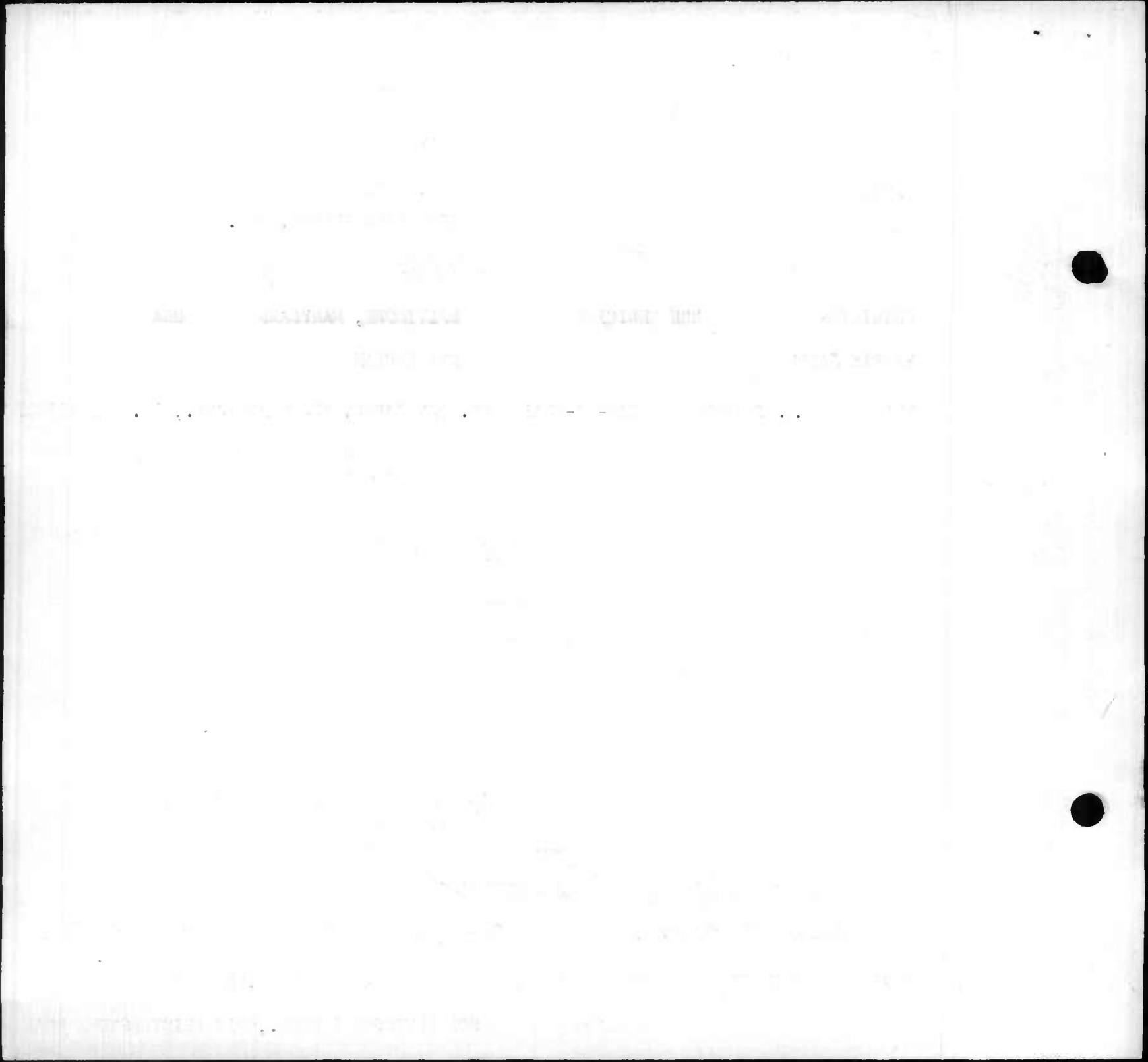
B-220 72 06412		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06412	
BIRTH NO.		STATE OF MARYLAND-DHE		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mary Bigos		2. DATE AND HOUR OF DEATH 7-3-72 6:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 9 North Charles Gen. Hosp.		A. STATE Md. B. COUNTY Baltimore			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 2724 N. Charles St. Baltimore, Md.		C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8-30-09	
13. FATHER'S NAME Ignatius Bigos		14. MOTHER'S MAIDEN NAME Katherine Romecki		9. AGE (In years last birthday) 62	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 217-16-4568		11. BIRTHPLACE (State or foreign country) Poland	
17. INFORMANT Daughter: Mrs. Marie C. Crouse		12. CITIZEN OF WHAT COUNTRY U.S.A.			
18. 444.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Mesenteric Thrombosis			
ANTECEDENT CAUSES		(B) Bronchopneumonia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 6-21-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obst.		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-19 1972 to 7-3 1972 that (I) (we) last saw the deceased alive on 7-3 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nereiso A de Borja		23B. DATE SIGNED 7-3-72		23C. PHYSICIAN'S NAME (Type) Nereiso A de Borja	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-72		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT JUN 11 1972		25B. NAME OF REGISTRAR Andrew H. Weston		25C. FUNERAL DIRECTOR John J. Duda	
25D. ADDRESS 7922 Wise Ave. Dundalk, Md. 21222					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

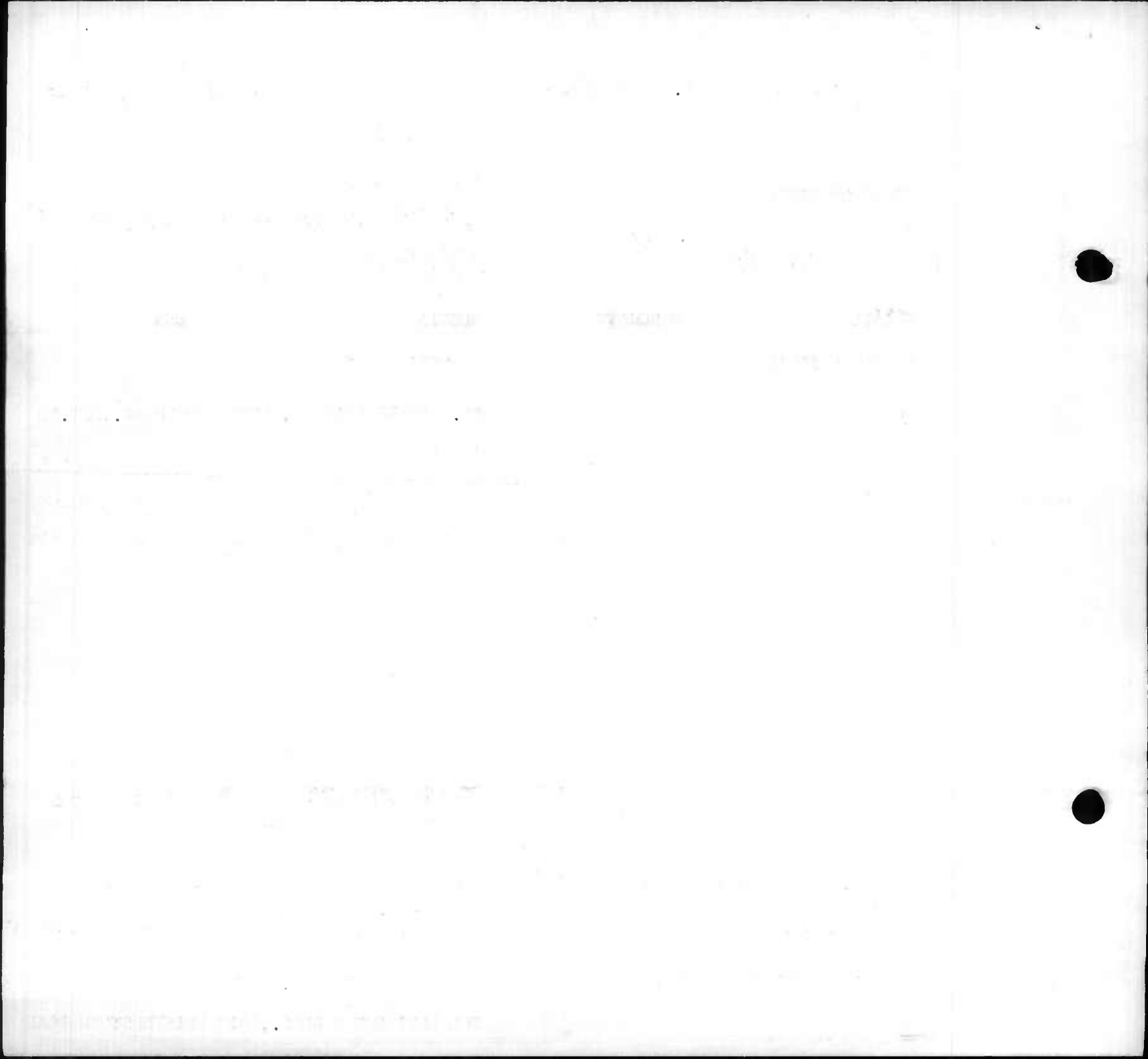
BALTIMORE CITY HEALTH DEPARTMENT				72 06413	
T-100				72 06413	
BIRTH NO. STATE OF MARYLAND DEED				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		Dr. JAFFE, Albert		2. DATE AND HOUR OF DEATH 7/8/1972 539 P.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION CHESUT SINAI Hospital			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY BALTO		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 130 SLADE AVENUE, APT. 202		
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/98	9. AGE (In years last birthday) 74	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
PHYSICIAN		MEDICINE		BALTIMORE, MARYLAND	
13. FATHER'S NAME HARRIS JAFFE			14. MOTHER'S MAIDEN NAME EVA KAPLAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES W.W. I ARMY		220-44-3711		MRS. RAY JAFFE, 130 SLADE AVE., APT. 202 #21208	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE Cerebro-Vascular Accident with Right Hemiplegia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/1/1972 7/8/1972		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Hypertensive C.V.D. Jew years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			None		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1 1972 to July 8 1972 that (I) (we) last saw the deceased alive on July 8 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard J. Cohen M.D.		23B. DATE SIGNED 7/8/1972		23C. PHYSICIAN'S NAME (Type)	
DA. BERNARD. J. COHEN		23D. ADDRESS The Marylander Apt - 3501 St. Paul St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/10/72		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW	
BURIAL				24D. LOCATION (City, town, or county) (State) REISTERSTOWN, MD MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Audrey Houston		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-255 72 06414		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
STATE OF MARYLAND		REG. NO. 72 06414	
1. NAME OF DECEASED (Type or Print) BENJAMIN M. REISMAN		2. DATE AND HOUR OF DEATH JULY 7, 1972 7:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY MARY LAND BALTO 5300	
5. SEX MALE		6. RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/5/95	
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PHILIP REISMAN		14. MOTHER'S MAIDEN NAME TOBA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. NETTIE REISMAN, 6978 MARSUE DR., APT. 1D		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		CAUSE OF DEATH Acute myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Emboli (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (C) None APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 3 months 6 months	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 17 1972 to JULY 7 1972 that (I) (we) last saw the deceased alive on JULY 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Manuel Levin		23B. DATE SIGNED 7/7/72	
23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN M.D.		23D. ADDRESS 6101 PARK HTS AVE BALTO MD 21215	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/9/72	
24C. NAME OF CEMETERY OR CREMATORY FORBAND		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1972		25B. NAME OF REGISTRAR Sidney W. Horton	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-530 72 06415		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06415	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LAND, LINDA H.		7-8-72 9:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
SINAI HOSPITAL		MD. BALTIMORE		2740	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		BALTIMORE, MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
GEORGE J. HOFFMAN		BESSIE GLASER		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				MR. EDWARD LAND, 2700 D JENNER ROAD #21209	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 MO.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				NO YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 6-23-72 to 7-8-72 that (we) last saw the deceased alive on 7-8-72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Ronald P. Byank, M.D.		7-8-72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
RONALD P. BYANK, M.D.		SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		7/10/72		ANSHE NEISER	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 11 1972		Sol Levinson		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
25D. LOCATION (City, town, or county)		25E. ADDRESS			
ROSEDALE, MARYLAND					

7/28/72 - Letter from Sinai Hospital, Ronald Byank, M.D. Letter dated July 25, 1972.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06416	
CERTIFICATE OF DEATH					
BIRTH NO. <u>R-324</u>		STATE OF MARYLAND - DHMH		2. DATE AND HOUR OF DEATH <u>7 7 72</u> <u>8:35PM</u> M.	
1. NAME OF DECEASED (Type or Print) <u>RIDGELY BENJAMIN C.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>ST AGNES HOSPITAL</u> <u>BALTIMORE, MARYLAND</u>			A. STATE <u>MD.</u> B. COUNTY <u>HOWARD</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>ELICOTT CITY</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9 28 97</u> 9. AGE (In years last birthday) <u>74</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>Am. Sugar</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>JOHN RIDGELY</u>			14. MOTHER'S MAIDEN NAME <u>KATHERINE (HIPSLEY)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>216 10 9674</u>		
			17. INFORMANT ADDRESS <u>9674 - ST AGNES HOSPITAL, BALTO., MD.</u>		
18. <u>1541</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Carcinoma of Rectum</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>24 hr.</u> <u>10 yr.</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>7 7</u> 19 <u>72</u> to <u>7 7</u> 19 <u>72</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>7 7</u> 19 <u>72</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>7/7/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Daniel Huerta</u>				23D. ADDRESS <u>ST AGNES HOSPITAL, BALTO., MD. 21228</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-11-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>M t. View Cem etery</u>	
24D. LOCATION (City, town, or county) <u>West Friendship</u>		(State) <u>Howard</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1972</u>		25B. NAME OF REGISTRAR <u>Arlene Robinson</u>		25C. FUNERAL DIRECTOR <u>Harry W. Haight</u> ADDRESS <u>Sylmarville, Md.</u>	

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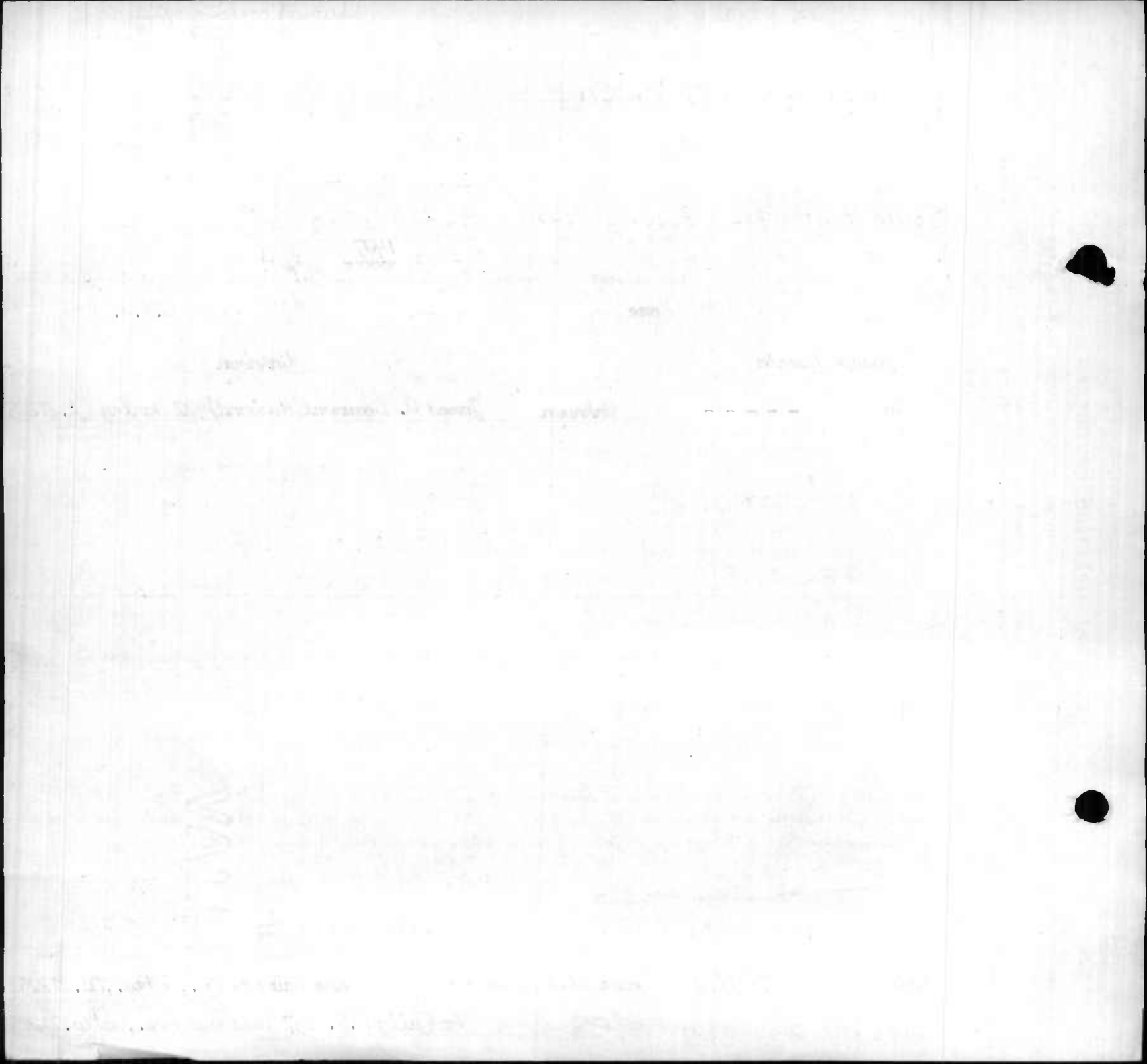
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 8-553		STATE OF MARYLAND - DI		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06417	
1. NAME OF DECEASED (Type or Print) Beaumont, Helen				2. DATE AND HOUR OF DEATH 7-7-'72 10:30 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD South Baltimore General Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY 2544					
FULL NAME OF HOSPITAL OR INSTITUTION 43				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 922 Dantry Ct.					
5. SEX M F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1907 Oct 13, 1907		9. AGE (In years last birthday) 64		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Huerta				14. MOTHER'S MAIDEN NAME Bertha Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT James O. Beaumont (Husband)			
				ADDRESS 922 Dantry Ct. 21225					
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Ac. Myocardial Infarction				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atherosclerosis				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) Cardiogenic Shock					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION None				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Not applicable		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-7-1972 to 7-7-1972 , that (I) we lost saw the deceased olive on 7.7.72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]						23B. DATE SIGNED 7.7.72			
23C. PHYSICIAN'S NAME (Type) D.S. SAWHNEY						23D. ADDRESS 3001 S. Hanover St. Balto. Md. 21225			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/72		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Balto., Md. 21225			
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972				25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Mc Cully F.H.			
						ADDRESS 237 Patapsco Ave., Balto. 21225			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 06418	
CERTIFICATE OF DEATH				REG. NO. 72 06418	
BIRTH NO. 0-600		72 06418			
1. NAME OF DECEASED (Type or Print) <i>O'Hayer, Thomas Aquinas</i>		2. DATE AND HOUR OF DEATH <i>7-8-72 3:10 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i> <i>43</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>3613 Fairhaven Ave. 2505</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-16-1910</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Transit Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>William O'Hayer</i>		14. MOTHER'S MAIDEN NAME <i>Mary Peters</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-07-2487</i>		17. INFORMANT ADDRESS <i>Paul Klender 3327 Belsford Ct., Balto. 21222</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Pulmonary edema.</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Anuria.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>hypotension? #2 to Myocardial Infarction.</i> (C)			
19. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 4</i> 19 <i>72</i> to <i>July 8</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>July 8</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>P. J. J.</i>		23B. DATE SIGNED <i>7-8-72</i>		23C. PHYSICIAN'S NAME (Type) <i>PAVIN</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/11/1972</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 11 1972</i>		25B. NAME OF REGISTRAR <i>Sidney Johnston</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Mc Cully F.H. 237 Patapsco Ave. Balto. 21225</i>	

1910 - 1911

1911 - 1912

1912 - 1913

1913 - 1914

1914 - 1915

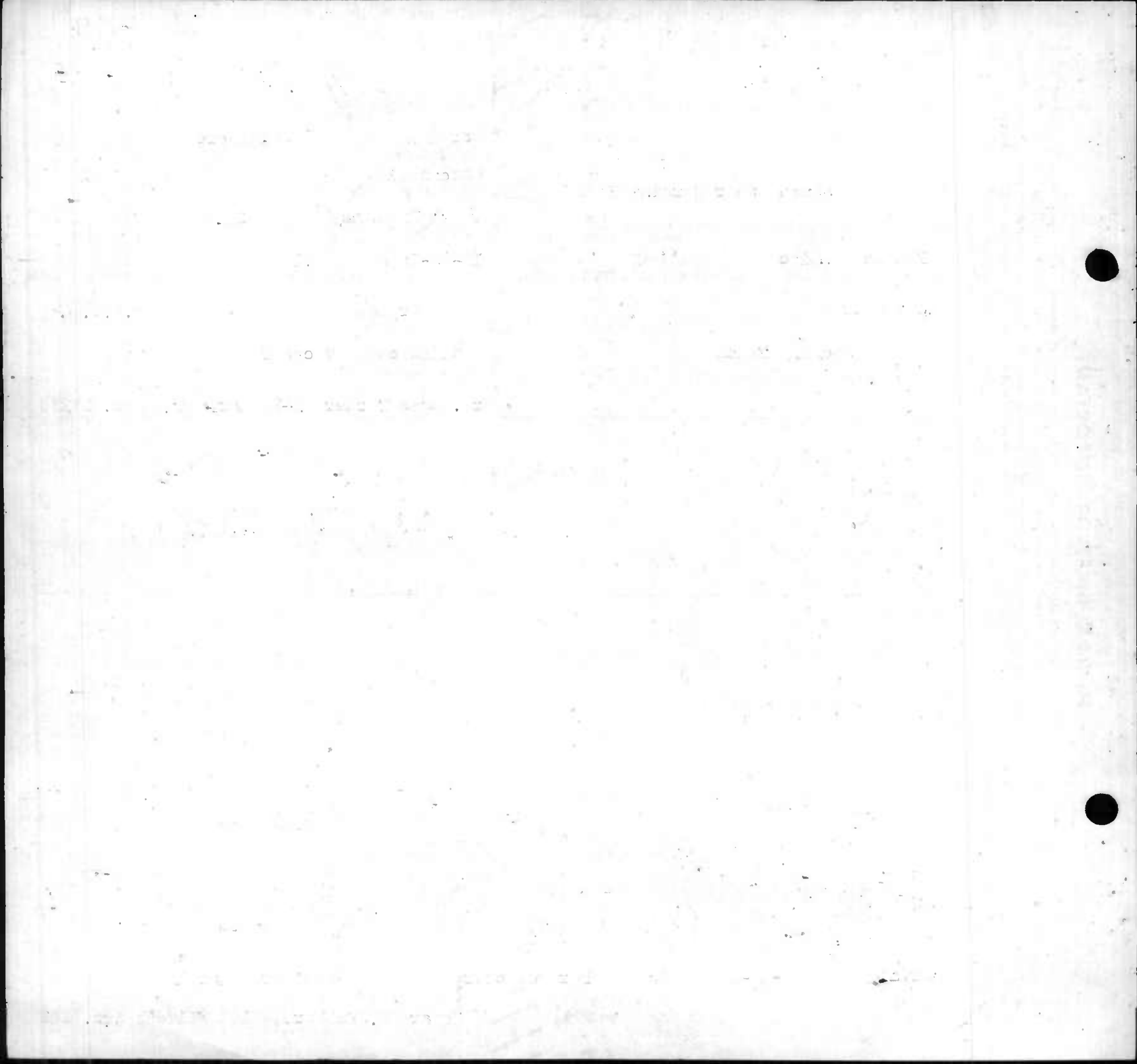
1915 - 1916

1916 - 1917

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

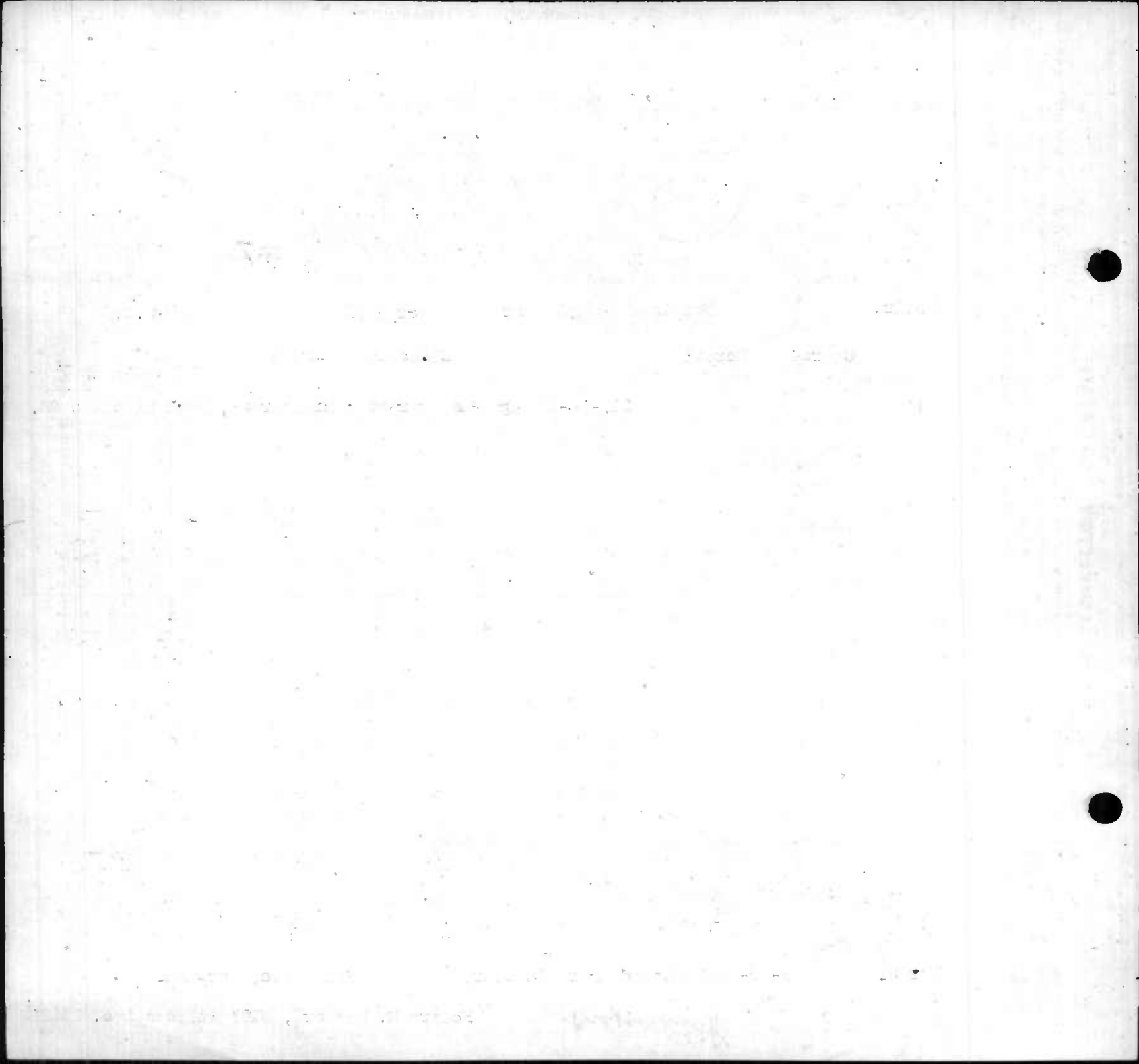
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 06419	
B-200 - 72 06419		STATE OF MARYLAND - DEATH		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Birdie Bush				2. DATE AND HOUR OF DEATH 7/6/72 9 15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Caton Manor Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5 Smith Lane 21228			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-1880	9. AGE (In years last birthday) 91	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Jacob Fontz				
14. MOTHER'S MAIDEN NAME Elizabeth Vienoff			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Mrs. Emma Turner, 2420 Marbourne Ave. 21230				
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the colon (B) WITH GENERALIZED METASTASIS DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 4/21 1972 to 7/6 1972, that (1) (we) last saw the deceased alive on 7/6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Herbert J. Levickas MD				23B. DATE SIGNED 7/6/72		23C. PHYSICIAN'S NAME (Type) Herbert J. Levickas	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-1972		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Lindsay H. Horton		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	



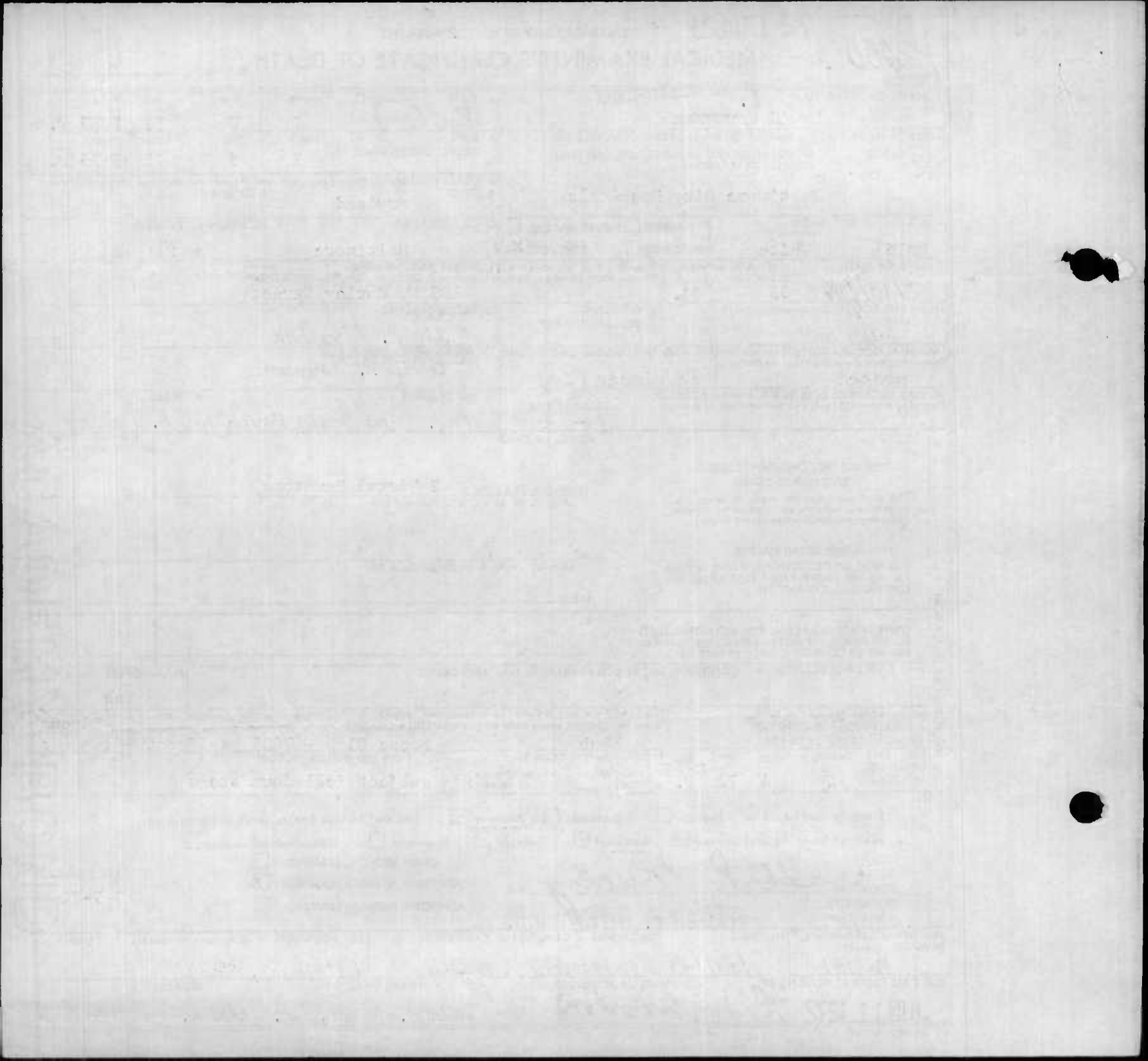
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 66420	
L-365 72 66420		BIRTH NO. 72 66420		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Leatherman, Bessie C</i>		2. DATE AND HOUR OF DEATH <i>7/6/72 12 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Caton Manor Nursing Center -</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2551</i>			
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Maryland School Board</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Conrad Herpel</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Mauhl</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-54-2698</i>		17. INFORMANT ADDRESS <i>Miss Margaret Leatherman, 3600 Hineline Rd. 21229</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>412.4 I Cardio Respiratory arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Extensive thrombosis, mid lobe of artery left</i>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <i>ASEV.D</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>UTI</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5-4</i> 19 <i>72</i> to <i>7-5</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>July 6</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Alexander Eugene MD</i>				23B. DATE SIGNED <i>July 6/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALEXANDER EUGENE MD</i>				23D. ADDRESS <i>St Agnes Med. Center Baltimore 21229</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-10-1972</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 11 1972</i>		25B. NAME OF REGISTRAR <i>Sidney Whitson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>	



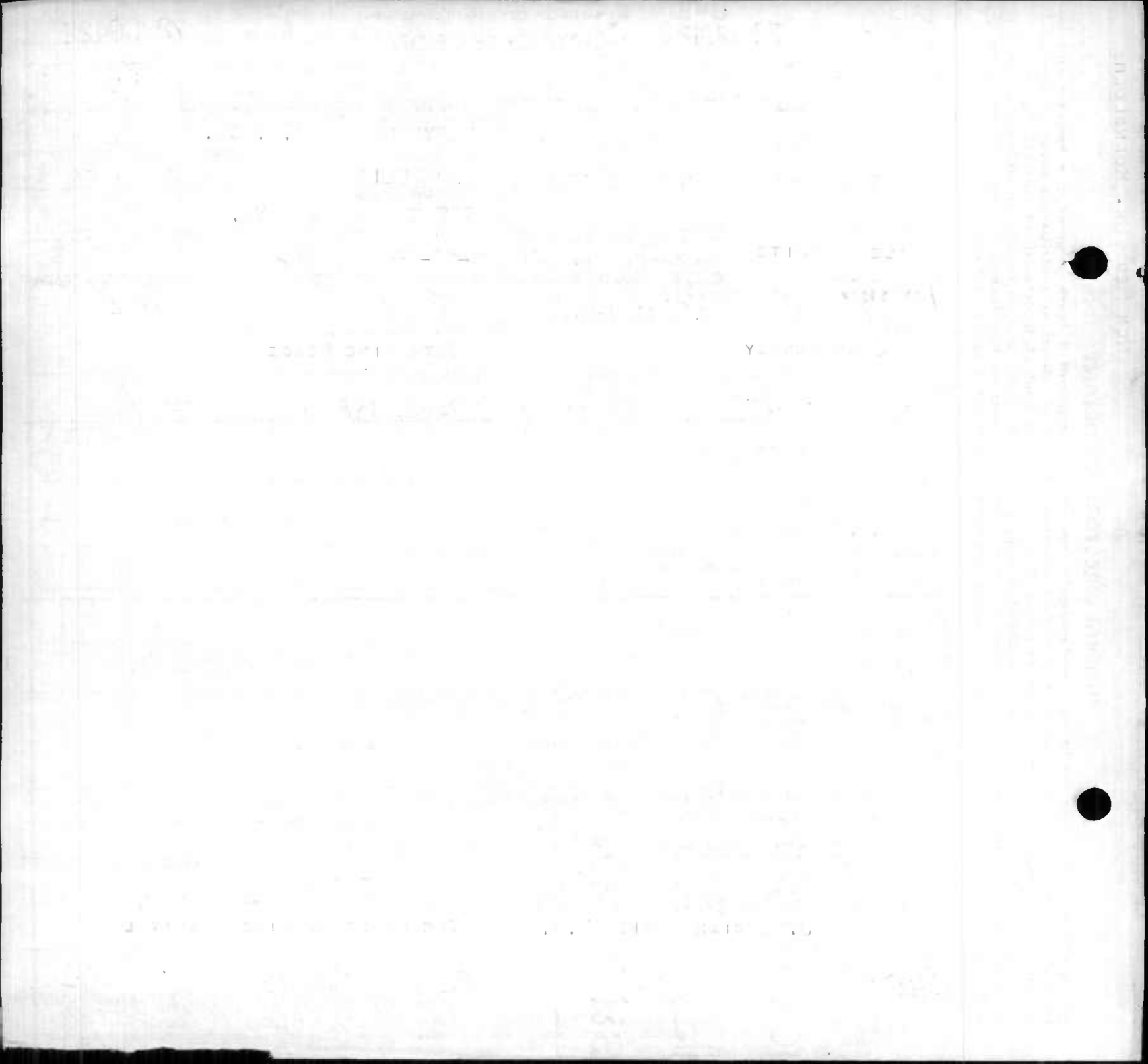
BIRTH NO.		STATE OF MARYLAND - DHME		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 72 00421	
1. NAME OF DECEASED (Type or Print) David Houseman				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 7 Day 6 Year 72		Hour 5:55 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals				3. DATE PRONOUNCED DEAD Month 7 Day 6 Year 72		Hour 5:55 P. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 601				6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 5/10/'09 63				10. AGE (In years lost birthday) 63		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mother's				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME David R. Houseman			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 273-03-803B		18. INFORMANT Mrs. Mina Bewig Davis		ADDRESS 165 N. Curley St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE Subdural Hematoma DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2/2/72				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) club		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Edgewood, Md.		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 7 4 72 8:25 P. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? subject fell down steps		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/10/'72		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT JUN 11 1972				25B. NAME OF REGISTRAR Sidney Winston		25C. FUNERAL DIRECTOR John A. Moran, Inc.		ADDRESS 3000 E. Baltimore St	



FUNERAL DIRECTOR: IMPORTANT

VS 150-REV. 1/1/68

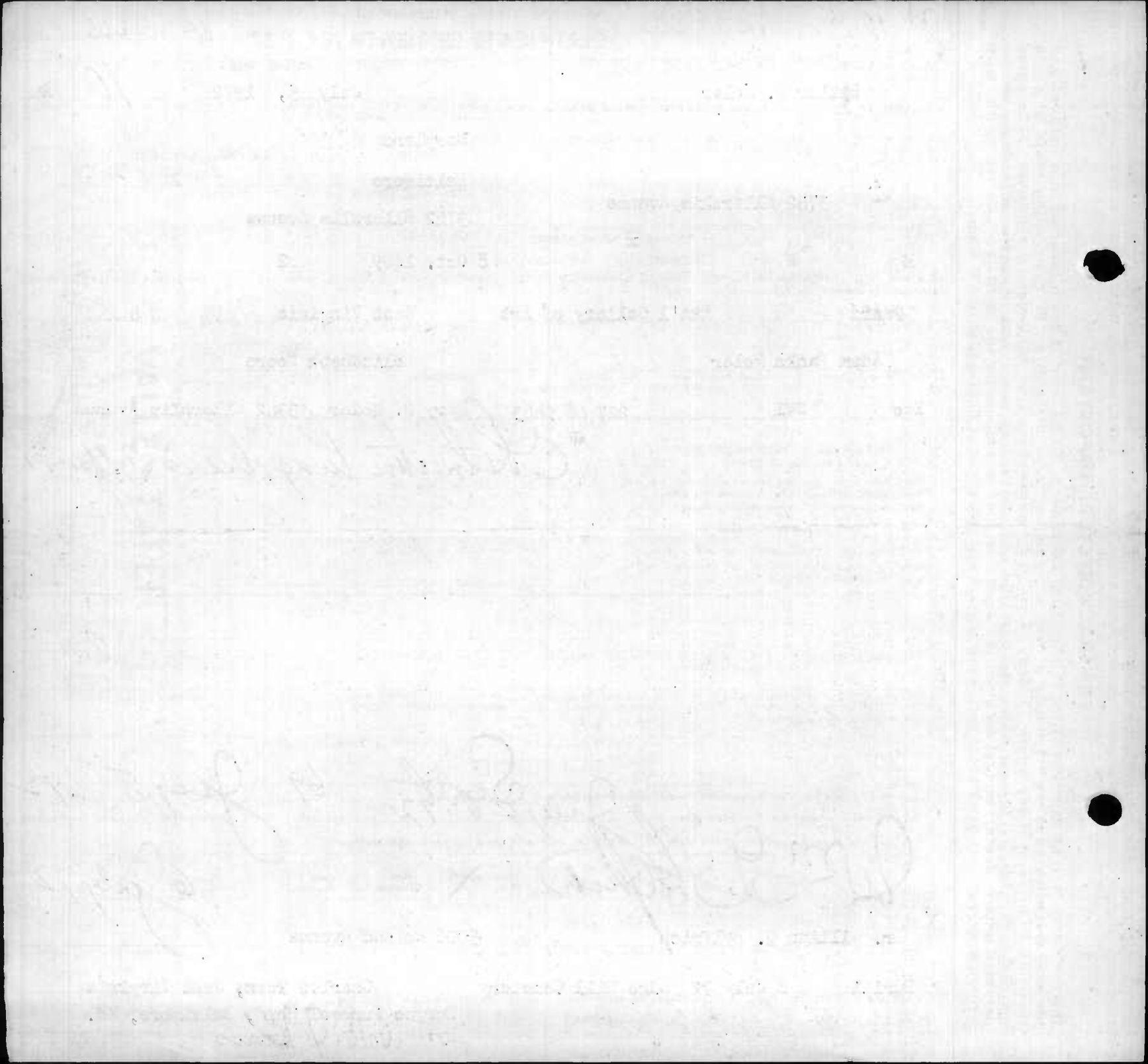
Baltimore City Health Department					
Certificate of Death			Reg. No.		
72 06422			72 06422		
Birth No.			Date and Hour of Death		
Name of Deceased (Type or Print)			Date and Hour of Death		
James F. Kenney			July 9, 1972 4:55 PM		
Place in Baltimore, Maryland, where pronounced dead			Usual Residence (Where deceased lived, if institution; residence before admission)		
Full Name of Hospital or Institution (If not in hospital or institution, give street address or location)			A. State B. County		
THE JOHNS HOPKINS HOSPITAL			MARYLAND A.A. CO.		
C. City or Town D. Inside City Limits?					
ANNAPOLIS YES [X] NO []					
E. Street and Number					
707 CHESAPEAKE AVE.					
Sex Race Married Never Married Widowed Divorced			Date of Birth Age (In years last birthday) If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
MALE WHITE [X] NEVER MARRIED [] WIDOWED [] DIVORCED []			1-10-14 58		
10A. Usual Occupation (Give kind of work done during most of working life, even if retired)			10B. Kind of Business or Industry		
SALESMAN			SALESMAN		
11. Birthplace (State or foreign country)			12. Citizen of what country?		
TEXAS			U.S.A.		
13. Father's Name			14. Mother's Maiden Name		
JOHN KENNEY			CATHERINE MEADE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. Social Security No.		
YES WWII			216-05-6019		
17. Informant Address					
ADELE KENNEY #4					
Cause of Death			Approximate Interval Between Onset and Death		
(A) Immediate Cause					
EXSANGINATION					
(B) Ruptured Abd. Aortic Aneurysm					
(C) Insufficient Coagulation					
Antecedent Causes					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the underlying condition last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. Date of Operation			19B. Condition for which operation was performed		
7/9/72			Ruptured Aneurysm (Aortic)		
20A. Autopsy? (Yes or No)			20B. If Yes, were findings considered in certifying causes of death?		
NO					
21A. Accident was underlying or contributing cause of death (Initially medical examined)			21B. Place of Injury (e.g., in or about home, farm, factory, street, office bldg., etc.)		
[] CAUSE OF DEATH			21C. Where did injury occur? (If in Baltimore City, give exact location)		
21D. Time of Injury (Month) (Day) (Year) (Hour)			21E. Injury occurred While At Work [] Not While At Work []		
21F. How did injury occur?					
22. I certify that (I) (this hospital) attended the deceased from 10 AM July 9 1972 to 4:55 PM July 9 1972 that (I) (we) last saw the deceased alive at 4:50 PM July 9 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. Signature			23B. Date Signed		
J. Lucian Davis MD			July 9, 1972		
23C. Physician's Name (Type)			23D. Address		
J. LUCIAN DAVIS M.D.			THE JOHNS HOPKINS HOSPITAL		
24A. Burial or Cremation Removal (Specify)			24B. Date		
BURIAL			7-12-72		
24C. Name of Cemetery or Crematory			24D. Location (City, town, or county) (State)		
Holy Redeemer			Balto Md.		
25A. Date Rec'd by Health Dept.			25B. Name of Registrar		
JUN 11 1972			Lidney Horton		
25C. Funeral Director Address					
John M. Lyons & Sons Annapolis, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460		72 06423		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06423	
BIRTH NO.				STATE OF MARYLAND-DEMR			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Butler H. Moler				July 5, 1972 10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
00		3742 Ellerslie Avenue		Maryland		901	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 Oct. 1889	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Guard		Nat'l Gallery of Art		West Virginia		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Adam Banks Moler				Elizabeth Moore			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		WWI		227 48 9443		Mary H. Moler 3742 Ellerslie Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				3 Years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While <input checked="" type="checkbox"/> Work At Work					
22. I certify that (I) (this hospital) attended the deceased from Sept 19 69 to July 5 19 72, that (I) (we) last saw the deceased alive on July 5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. William G. Helfrich				6 July 72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. William G. Helfrich				5006 Roland Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8 July 72		Edge Hill Cemetery		Charles Town, West Virginia	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 11 1972		Wm J. Houston		Burgee Funeral Home, Baltimore, Md.			
VS 150-REV. 1/1/68				By: Walter J. Henss			



B-650 72 06424 BALTIMORE CITY HEALTH DEPARTMENT
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 72 06424
 BIRTH NO. STATE OF MARYLAND-DEMH REG. NO.

1. NAME OF DECEASED (Type or Print) HARRY W. BROWN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2211 Eutaw Place		3. DATE PRONOUNCED DEAD Month Day Year Hour July 8, 1972 6:35 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Jan 6, 1887		10. AGE (In years last birthday) 85 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Yordella Bishop		ADDRESS 1829 Wilanvale St.	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of stomach with metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			

20A. DATE OF OPERATION 7/13/72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Ronald N. Kornblum, M.D.** Deputy CHIEF MEDICAL EXAMINER ☒
 EXAMINER'S NAME (Type) **Ronald N. Kornblum, M.D.** ASSISTANT MEDICAL EXAMINER ☐
 ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **7/8/72**

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/72		24C. NAME of CEMETERY or CREMATORY Abraham's Memorial		24D. LOCATION (City, town or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Sidney W. Hinton		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Broadway St.	

Blank lined paper with two binder holes on the right side. Faint, illegible handwriting is visible throughout the page, appearing as bleed-through from the reverse side. The text is mirrored and cannot be accurately transcribed.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-552		72 06425		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06425	
BIRTH NO.				STATE OF MARYLAND - DHMH			
1. NAME OF DECEASED (Type or Print) SEMONES, Mrs SUSIE E.				2. DATE AND HOUR OF DEATH 7/8/72 1:26 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD		B. COUNTY BALTIMORE.	
Church Home & Hospital		35		C. CITY OR TOWN City.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				201 N. BROADWAY ST. MT. 14C 91231			
5. SEX F.	6. RACE White.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/93	9. AGE (in years last birthday) 79	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER.		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) VA. Tazewell		12. CITIZEN OF WHAT COUNTRY? AMER.	
13. FATHER'S NAME JACKSON SMITH.				14. MOTHER'S MAIDEN NAME SWEPTIE, HICKS.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213540113		17. INFORMANT ADDRESS Goldie Benton 1822 E Bank St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) TERMINAL STATE of Carcinoma of the Lungs. DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE Cancer of the lungs. (B) A.C.U.D. Atrial fibrillation (C) MALNUTRITION. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediately years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/5/72 19 to 7/8/72 19 that (I) (we) last saw the deceased alive on 7/8/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Swaminathan				23B. DATE SIGNED 7/8/72.		23C. PHYSICIAN'S NAME (Type) R. SWAMINATHAN.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial				24B. DATE July 12 1972		24C. NAME of CEMETERY or CREMATORY HOLY HILL Cemetery	
24D. LOCATION WHITE MARSH MARYLAND				25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972			
25B. NAME OF REGISTRAR Sidney W. Horton				25C. FUNERAL DIRECTOR ADDRESS Dipper Brothers 7110 Belair Rd			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

STATE OF MARYLAND - DISTRICT

72 06426

1. NAME OF DECEASED

(Type or Print)

ALEXANDER DIMIRKOW

2. DATE

Known ☐Estimated ☐

Month

Day

Year

Hour

3. DATE

PRONOUNCED DEAD

Month

Day

Year

Hour

July 9, 1972

1:00 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 CHURCH HOME AND HOSPITAL

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

105

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

March 8, 1955

10. AGE (In years)

lost birthday 17

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2222 E. Lombard Street

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD.

12. CITIZEN OF

WHAT COUNTRY? U.S.A.

13. FATHER'S NAME

John Dimirkow

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

STUDENT

14B. KIND OF BUSINESS OR INDUSTRY

AT SCHOOL

15. MOTHER'S MAIDEN NAME

MARIA Dimirkow

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

213541504

18. INFORMANT

ADDRESS

MARIA Dimirkow 2222 E Lombard St

19.

304.9

CAUSE OF DEATH

Intravenous narcotism

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

22

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, MD

Deputy

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/9/72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/13/1972

24C. NAME of CEMETERY or CREMATORY

ST Andrew's Cem

24D. LOCATION (City, town, or county) (State)

GERMAN HILL Rd Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 11 1972

25B. NAME OF REGISTRAR

Aidey Hinton

25C. FUNERAL DIRECTOR

Dippel Bros 1800 E Lombard St

ADDRESS

NO _____ 513241204 Maria Dimirkow 5555 E Lombard ST

STUDENT AT SCHOOL Maria Dimirkow
Baltimore Md U.S.A. John Dimirkow

March 8, 1952

Dear Mr/ Mrs Stankovic (or German this is Mr)
Digger Rose New York

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-620 72 06427		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 72 06427		REG. NO. 72 06427	
1. NAME OF DECEASED (Type or Print) SIERACKI, MR. JAMES		2. DATE AND HOUR OF DEATH 7/10/72 15:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME 100 N. BROADWAY & HOSPITAL BALTIMORE, Md. 21231		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2611 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 924 S. BOULDIN ST.	
5. SEX MALE	6. RACE A W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/1886
9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLEMENT SIERACKI		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 213 015154	
17. INFORMANT MEDICAL CHART		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia & Dehydration ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-10-1972 to 7-10-1972 that (I) (we) last saw the deceased alive on 7-10-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. Kim		23B. DATE SIGNED 7/10/72	
23C. PHYSICIAN'S NAME (Type) JUNG-HO KIM		23D. ADDRESS CHURCH HOME & HOSPITAL 100 N. BROADWAY, BALTIMORE, MD. 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/72	
24C. NAME of CEMETERY or CREMATORY ST. STANISLAUS Cem		24D. LOCATION (City, town, or county) (State) DUNDALK AVE BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR Dippel Bros		25D. ADDRESS 1800 E. LOMBARD ST.	

1000000

1000000

1000000

72 06428

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 06428

BIRTH NO. STATE OF MARYLAND-DHMT

1. NAME OF DECEASED (Type or Print) WALTER RAZWELL Rozwill		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 7203 Moyer Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 9 1972 5:35p M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN New York	
9. DATE OF BIRTH 7-15-1908		10. AGE (In years lost birthday) 64	
11. BIRTHPLACE (State or foreign country) WOLYN DUBNO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER		14B. KIND OF BUSINESS OR INDUSTRY BAR	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 112 035710	
18. INFORMANT STEVE ROZWELL		ADDRESS 6910 Chamizos Rd	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic Cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-10-72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/13/1972	
24C. NAME of CEMETERY or CREMATORY HOLY TRINITY Cem		24D. LOCATION (City, town, or county) (State) ELKridge Cemetery Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Trinity Whorton	
25C. FUNERAL DIRECTOR Dippell Bros.		ADDRESS 710 BELAIR Rd	

7/19/72 - Letter from Medical Examiner's Office

APC.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 66429	
B-652				CERTIFICATE OF DEATH	
BIRTH NO. 1		STATE OF MARYLAND - DEPT		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Burns, Calvin A. Carlton				7/9/72 11:45 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE Maryland B. COUNTY 2864	
FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital Emergency Room		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 7/24/72		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/22/21 9. AGE (In years last birthday) 51		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet maker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ellicott City, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin A. Berrings		14. MOTHER'S MAIDEN NAME Edna Grimes			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-14-1122		17. INFORMANT Mr. Ralph Burns 108 Diener Place ADDRESS	
18. 157.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Tumoral Coagulation (B) DUE TO, OR AS A CONSEQUENCE OF: Multiple Metastasis (C) Adenocarcinoma Pancreas		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION May 72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma Pancreas		20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 9 1972 to July 9 1972, that (I) (we) last saw the deceased alive on July 8/10/72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alexander J. J. J.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ALEXANDRO MEDIC 1970		23D. ADDRESS St Agnes Hospital Emergency Room			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/72		24C. NAME of CEMETERY or CREMATORY Western Star Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Andrew J. J. J.		25C. FUNERAL DIRECTOR Mrs. Mary E. Law 802 Madison Ave. ADDRESS	

7/24/72 - Letter from St. Agnes Hospital. Signed by Patricia Woodward, 7/18/72.

AB

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 06430	
CERTIFICATE OF DEATH				REG. NO. 72 06430	
BIRTH NO. 72 06430					
1. NAME OF DECEASED (Type or Print) BARNETT WILLIAM SANDERS					
2. DATE AND HOUR OF DEATH 7/6/72 4:15 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MD HOSP 38			A. STATE MD B. COUNTY 1604		
5. SEX M			6. RACE NEGRO		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12/24/95		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			9. AGE (In years last birthday) 76		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME		
16. SOCIAL SECURITY NO. 215-10-7715			17. INFORMANT CHART		
18. 569.914199.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE GASTROINTESTINAL BLEEDING 24 HRS DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). PROBABLY METASTATIC CARCINOMA					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/1 19 72 to 7/6 19 72 that (I) (we) last saw the deceased alive on 7/6 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. A. Fleming MD				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) L. A. FLEMING MD				23D. ADDRESS UNIVERSITY HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-72		24C. NAME OF CEMETERY OR CREMATORY Carver Memorial Pk.	
24D. LOCATION (City, town, or county) (State) Harverl, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972			
25B. NAME OF REGISTRAR Sidney Whitton		25C. FUNERAL DIRECTOR W. F. H 1701 - Harvers St.			

During 2-10-72 Carver Memorial to Peace, Maryland
at the 11th 11-11-72

5-5301

BALTIMORE CITY HEALTH DEPARTMENT

72 06431

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06431

BIRTH NO. STATE OF MARYLAND - DEATH		2. DATE OF DEATH		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>	Month	Day	Year	Hour
1. NAME OF DECEASED (Type or Print)		Thomas B. Smith			7	6	72	3:50 P. M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		3. DATE PRONOUNCED DEAD			7	6	72	3:50 P. M.
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)								
00 254 N. Pine Street		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE		B. COUNTY		
		Maryland				402		
6. SEX	7. RACE	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH	10. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs.		E. STREET AND NUMBER				
1-23-14	58	Months Days Hours Min.		254 N. Pine Street				
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME				
Baltimore, Md.		U. S. A.		Unknown				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME				
Longshoreman				Ella Smith				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS		
No		218-03-0734		Mrs. Carolyn L. Wilson		3000 Resisterstown Rd.		
19. 412.41		CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE						Arteriosclerotic cardiovascular
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:						disease
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:						
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).								
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED						21. AUTOPSY? (Yes or No)
0								No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?				
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
William P. Mulloy, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		7-7-72		
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>								
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
Burial		7-10-72		Mt. Auburn Cemetery		Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS		
JUN 11 1972		Andrew W. Boston		Morton & Dyett F. H.		1701 Laurens St.		

10-17-77

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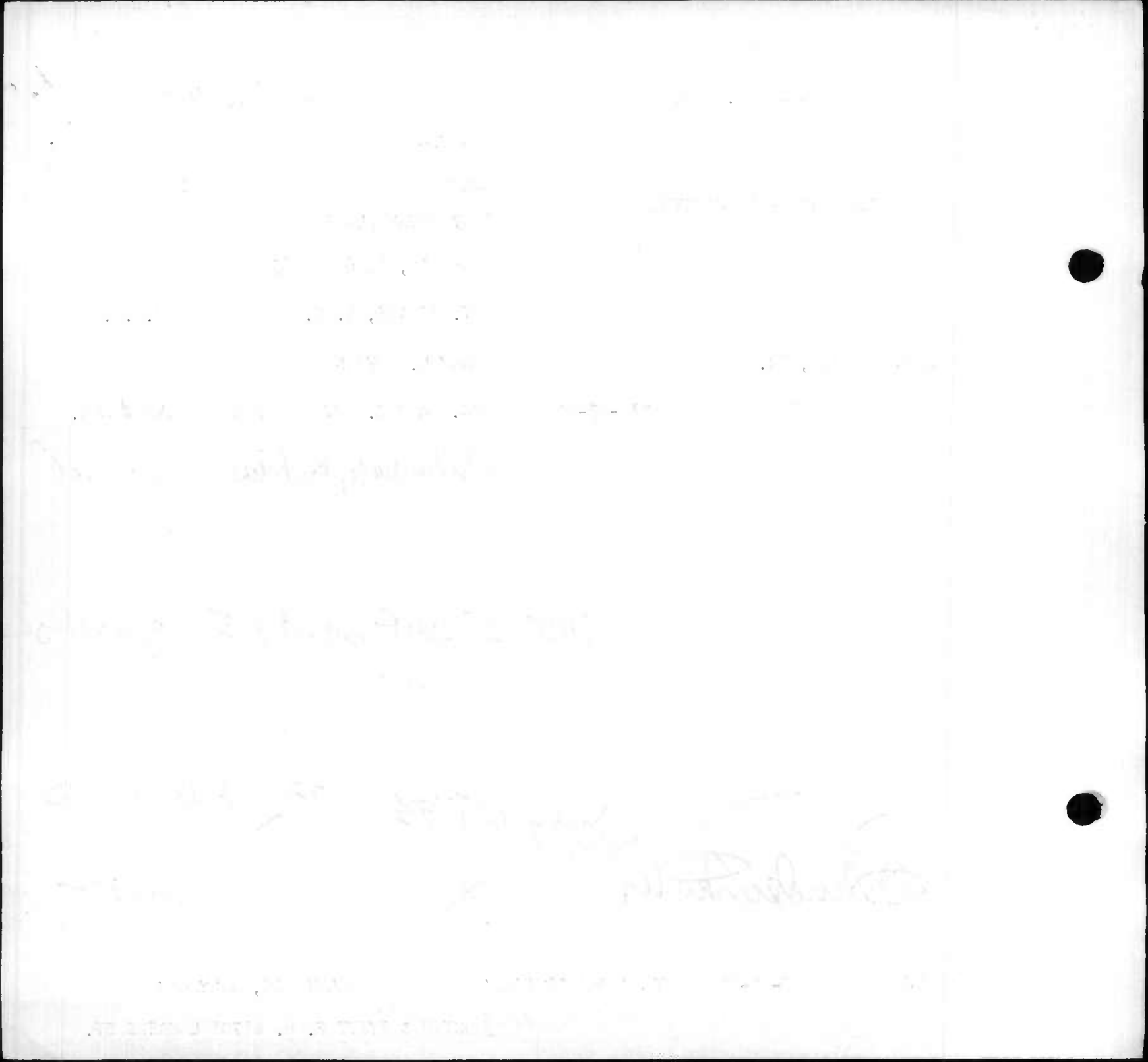
10-17-77

10-17-77

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06432		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06432	
BIRTH NO. STATE OF MARYLAND - DEATH				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
OSCAR M. HUTSON		July 6, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 78 MARYLAND GENERAL HOSPITAL		A. STATE MARYLAND			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1917 EUTAW PLACE			
5. SEX M	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 16, 1906	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ST. GEORGE, S. C.	
13. FATHER'S NAME OSCAR HUTSON, SR.		14. MOTHER'S MAIDEN NAME MARY L. HUTSON		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-03-0364		17. INFORMANT MRS. MARY E. HUTSON 4002 RIDGEWOOD AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 450X1 Pulmonary embolus		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HASCVD & CHF present MI		5 weeks	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 1972 to July 6 1972 that (I) (we) last saw the deceased alive on July 6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED 7/11/72		23C. PHYSICIAN'S NAME (Type) DEGREE 23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-12-72		24C. NAME OF CEMETERY or CREMATORY MT AUBURN CEMETERY	
24D. LOCATION BALTIMORE, MARYLAND		24E. NAME OF REGISTRAR <i>[Signature]</i>		24F. FUNERAL DIRECTOR MORTON & DYETT F. H. a1701 LAURENS ST.	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



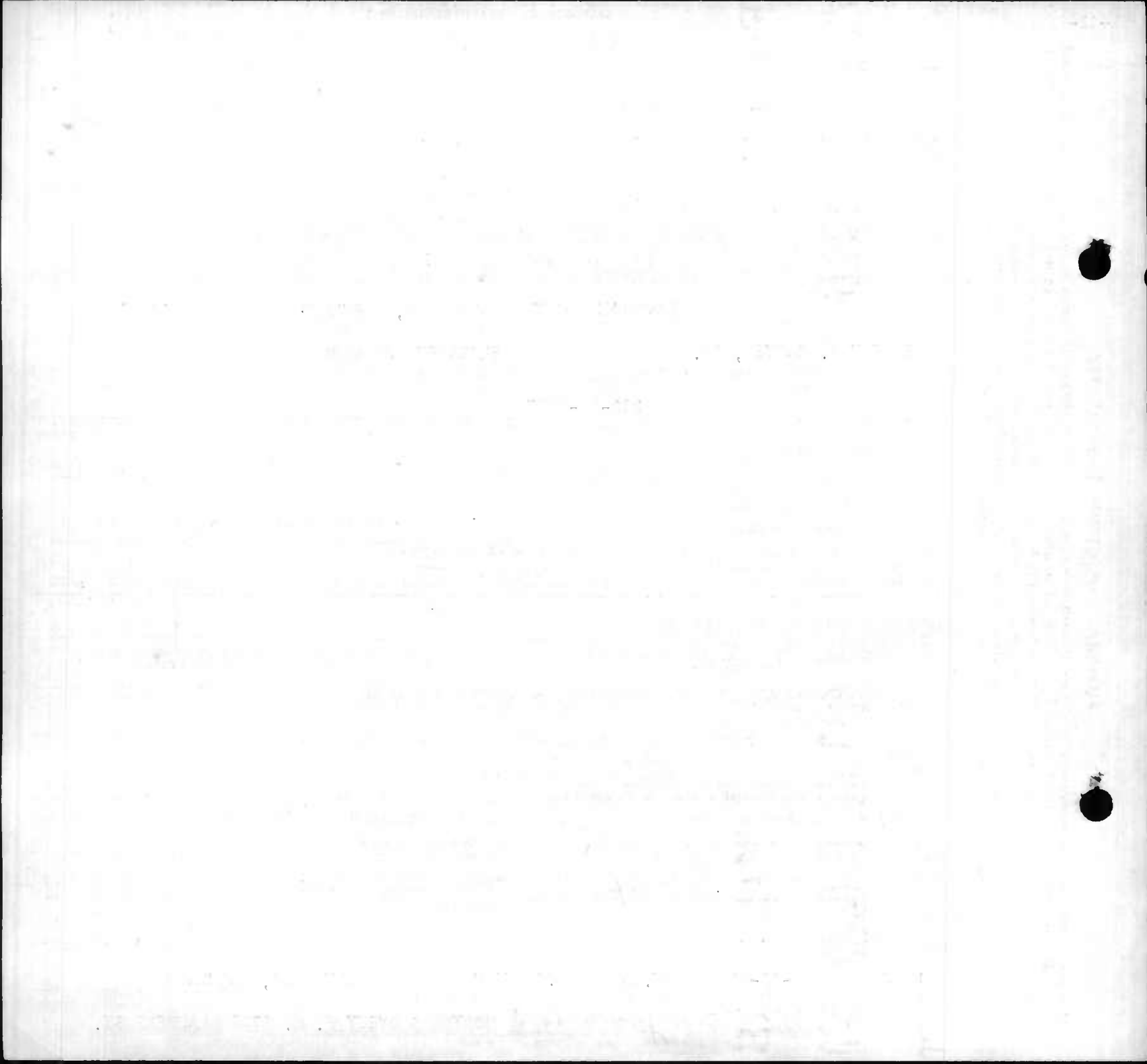
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 06433

72 06433
BIRTH STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) Herbert Carter		2. DATE AND HOUR OF DEATH July 9, 1972 8:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 31 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1506 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3009 Clifton Avenue	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (in years last birthday) 1/12/31 9. AGE (in years last birthday) 41 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY SPARROWS POINT	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HERBERT M. CARTER, SR.		14. MOTHER'S MAIDEN NAME ELIZABETH JOHNSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-26-5577	17. INFORMANT ADDRESS BCH RECORDS: 4940 Eastern Avenue 21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 436.0 I Cardiac Pump Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ? M.I. or Pulmonary Embolism HIVES Hypertension years CVA 5 DAYS		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) (D) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR HOURS years 5 DAYS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from 7/4 1972 to 7/9 1972 that (I) (we) last saw the deceased alive on 7/9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert L. Ruxin M.D.		23B. DATE SIGNED 7/9/72	
23C. PHYSICIAN'S NAME (Type) Robert Ruxin M.D.		23D. ADDRESS Baltimore City Hospitals Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-13-72	
24C. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEMETERY		24D. LOCATION BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Audrey H. Boston	
25C. FUNERAL DIRECTOR MORTON & DYETT F. H.		25D. ADDRESS 1701 LAURENS ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DHMH BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. **72 06434**

BIRTH NO. 72 06434		2. DATE AND HOUR OF DEATH JULY 8, 1972 1 6:30 A. M.	
1. NAME OF DECEASED (Type or Print) MADISON, WILLIAM		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE 6. RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-19-78 9. AGE (In years last birthday) 93	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
10B. KIND OF BUSINESS OR INDUSTRY Retired		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARSHALL MADISON		14. MOTHER'S MAIDEN NAME JOSEPHINE BROILS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-18-9689	
17. INFORMANT ADDRESS Mrs. Rose Epps 125 WESLEY AVE. 21228		18. CAUSE OF DEATH Central failure	
19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		20. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that M (this hospital) attended the deceased from JULY 6 19 72 to JULY 7 19 72 , that he (we) lost saw the deceased alive on JULY 7 19 72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) XXXX view the body after death.			
23A. SIGNATURE Kuang-yen Huang M.D.		23B. DATE SIGNED 07/08/72	
23C. PHYSICIAN'S NAME (Type) KUANG-YEN HUANG, M.D.		23D. ADDRESS XXXXX BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-1972	
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Sidney Houston	
25C. FUNERAL DIRECTOR 1735 Harford Ave.,		ADDRESS Marshall W. Jones, Jr.	

6:20 A. JULY 2, 1972

UNITED STATES

51222 DALLAS

AT 10:00 AM
JULY 2, 1972
1000 WEST 10TH AVENUE
DALLAS, TEXAS 75201

10-1-72

RECORD

JOHN CARROLL

JOHN CARROLL

JOHN CARROLL

10-1-72 - 10-1-72
ST. ANTHONY'S HOSPITAL
DALLAS, TEXAS 75201

JULY 7 1972
JULY 7 1972
JULY 7 1972

JOHN CARROLL
1000 WEST 10TH AVENUE
DALLAS, TEXAS 75201

JOHN CARROLL, M.D.
ST. ANTHONY'S HOSPITAL
DALLAS, TEXAS 75201

JOHN CARROLL, M.D.
ST. ANTHONY'S HOSPITAL
DALLAS, TEXAS 75201

JOHN CARROLL, M.D.
ST. ANTHONY'S HOSPITAL
DALLAS, TEXAS 75201

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 06435</u>	
BIRTH NO. <u>72 06435</u>							
1. NAME OF DECEASED (Type or Print) <u>ELLA Fletcher</u>		2. DATE AND HOUR OF DEATH <u>7-6-72</u> <u>4 30/A.</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1547</u>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Md.</u> <u>46</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>2117 DENISON ST</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-06-10</u>	9. AGE (in years last birthday) <u>61 yrs.</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES COX</u>		14. MOTHER'S MAIDEN NAME <u>MARY COX</u>					
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Rev. Elijah Harrison 727 Bartlett Ave. 21218</u>			
18. <u>4667</u> I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebro Vascular Accident</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>7-3-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-3-72</u> 19 <u>72</u> to <u>7-6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7-5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>LOURDES M. VICTORIA</u>		DEGREE		23B. DATE SIGNED <u>7-6-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>LOURDES M. VICTORIA</u>		DEGREE		23D. ADDRESS <u>Lutheran Hospital of Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-12-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary</u>		24D. LOCATION (City, town, or county) (State) <u>A.A. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1972</u>		25B. NAME OF REGISTRAR <u>Andrew H. Hinton</u>		25C. FUNERAL DIRECTOR <u>Marshall W. Jones</u>		ADDRESS <u>1735 Harford Av. 21213</u>	

NO One in N.H to give info.
To call back later, In meantime
coded to N.H. av

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-3001

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 06436

BIRTH NO.

72 06436

1. NAME OF DECEASED
(Type or Print)

Lossie Wyatt

2. DATE AND HOUR OF DEATH

7/10/72

8:15 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY
Balto. Md.

C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1532 Holbrook St. 21202

5. SEX

F

6. RACE

N

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

10/6/14

9. AGE (In years last birthday)

57

If Under 1 Yr. Months; Days

If Under 24 Hrs. Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lossie Johnson

14. MOTHER'S MAIDEN NAME

Joanna Johnson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Clinton Wyatt 1532 Holbrook Street

18. 197.8 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

Massive Gastric Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF:

(B)

Carcinoma of the Liver

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

1 (Month) 1 (Day) (Year) 1 (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from July 9 1972 to July 10 1972 that (I) (we) last saw the deceased alive on July 10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Tohrv OHE MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

July 10, 72

23C. PHYSICIAN'S NAME (Type)

Tohrv

OHE

MD

23D. ADDRESS

Mercy Hospital, Baltimore, MD

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-14-72

24C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

24D. LOCATION (City, town, or county) (State)

Anne Arundel Cty., Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 11 1972

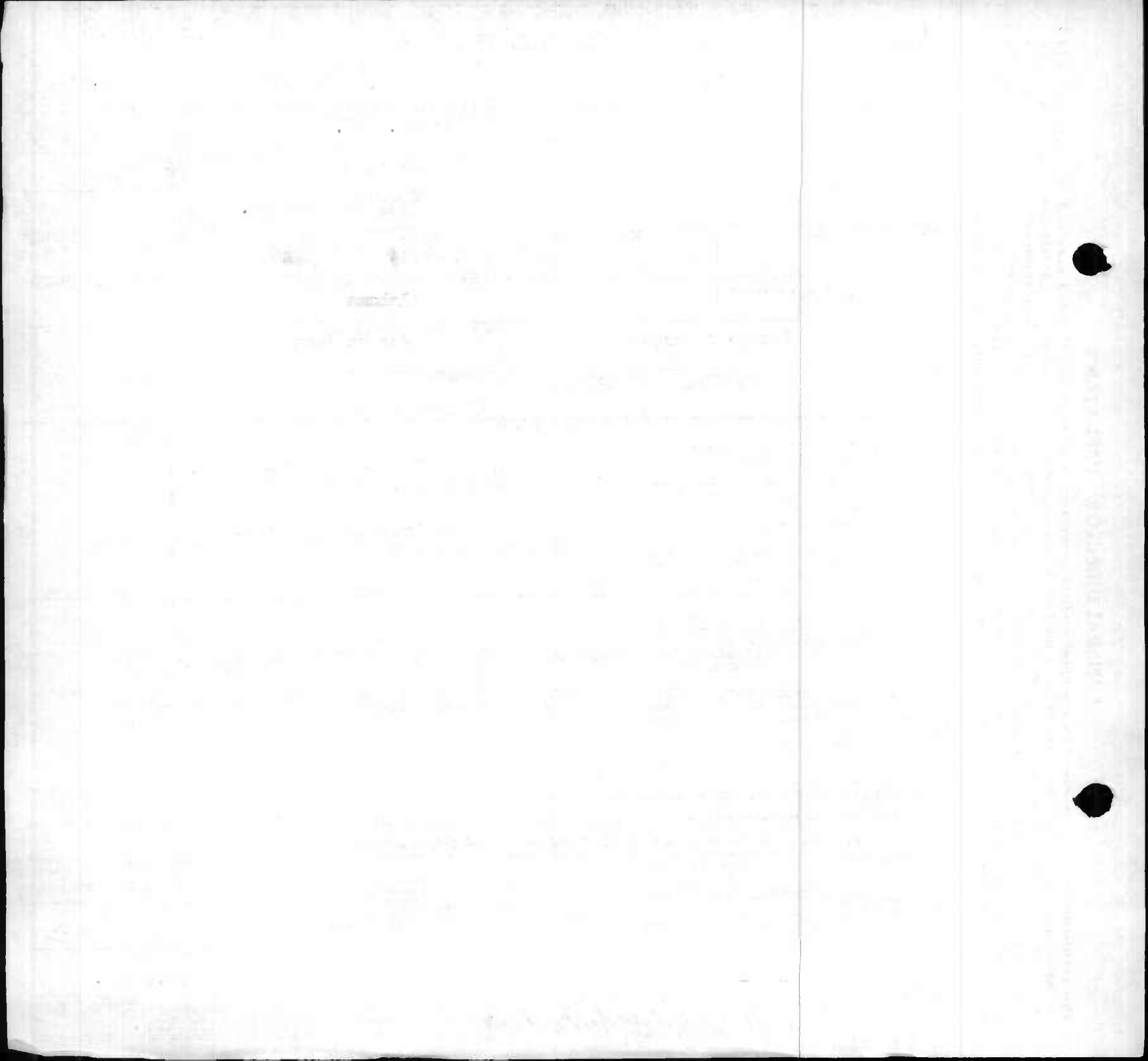
25B. NAME OF REGISTRAR

Sidney H. Heston

25C. FUNERAL DIRECTOR

Wm C March 928 E North Ave.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-352		72 06437		BALTIMORE CITY HEALTH DEPARTMENT		72 06437	
BIRTH NO.		72 06437		CERTIFICATE OF DEATH		-REG. NO. STATE OF MARYLAND-DEMO	
1. NAME OF DECEASED (Type or Print)		Adams, Robert, Jr.		2. DATE AND HOUR OF DEATH		7-7-72 9:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEATH		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF DECEASED IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET		Maryland Baltimore		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Caton Manor Nursing Center		Baltimore		YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>	
3330 Wilkens Avenue 7-17-72		E. STREET AND NUMBER		2731 Arbutus Ave.			
Baltimore, Maryland 21229							
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days	11. If Under 24 Hrs. Hours Min.	
Male	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-19-1882	89	5		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
TOL & DIE MAKER		TOL & DIE		Pennsylvania		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Obiadah Adams		Elizabeth Fields		17. INFORMANT		ADDRESS	
				ROBERT J. ADAMS, JR. 50 BRADSHAW		21222	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Sudden			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)					
II		Adenocarcinoma of the prostate					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/27 1972 to 7/7 1972, that (I) (we) lost saw the deceased alive on 7/7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED			
Herbert J. Levickas, MD		7/9/72					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Herbert J. Levickas		5404 East Drive 21227		CREMATION		10/14/72	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
GREEN MOUNT CREMATORY BALTO, MD.				JUN 11 1972		Audrey W. Horton	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. DATE REC'D BY HEALTH DEPT.		25F. NAME OF REGISTRAR	
Charles Funeral Home, Duval, MD. 21222							

7-17-1972 - Correction Form from Funeral Director -Ullrich Funeral Home

4210 Belair Road

Balto., Md. 21206

(John Ullrich)

HRS

7-200		72 06438		BALTIMORE CITY HEALTH DEPARTMENT		72 06438	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO. STATE OF MARYLAND-DEMH							
1. NAME OF DECEASED (Type or Print) DONALD E. FOX				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour July 8, 1972 5:22 A. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1903							
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH June 3, 1940		10. AGE (In years lost birthday) 32		E. STREET AND NUMBER 328 S. Fulton Avenue			
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Norman Arthur Fox			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Antenna Installation		15. MOTHER'S MAIDEN NAME Grace Stewart			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-34-7193		18. INFORMANT ADDRESS Leonard Keene 1702 Ramsey St., Balto. 21223			
19. E 980.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Overdose of alcohol and barbiturate (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Found 1800 Block W. Pratt Street			
22D. TIME OF INJURY (APPROX.) 7-6-72		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Ingested alcohol and barbiturate			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/8/72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/72		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Balto., Md. 21225	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		25B. NAME OF REGISTRAR Sidney W. Horton		25C. FUNERAL DIRECTOR ADDRESS Mc Cully F.H. 237 Patapsco Ave., Balto. 21225			

7-12-1972 - Completion of cause of death on a pending medical examiner death certificate.

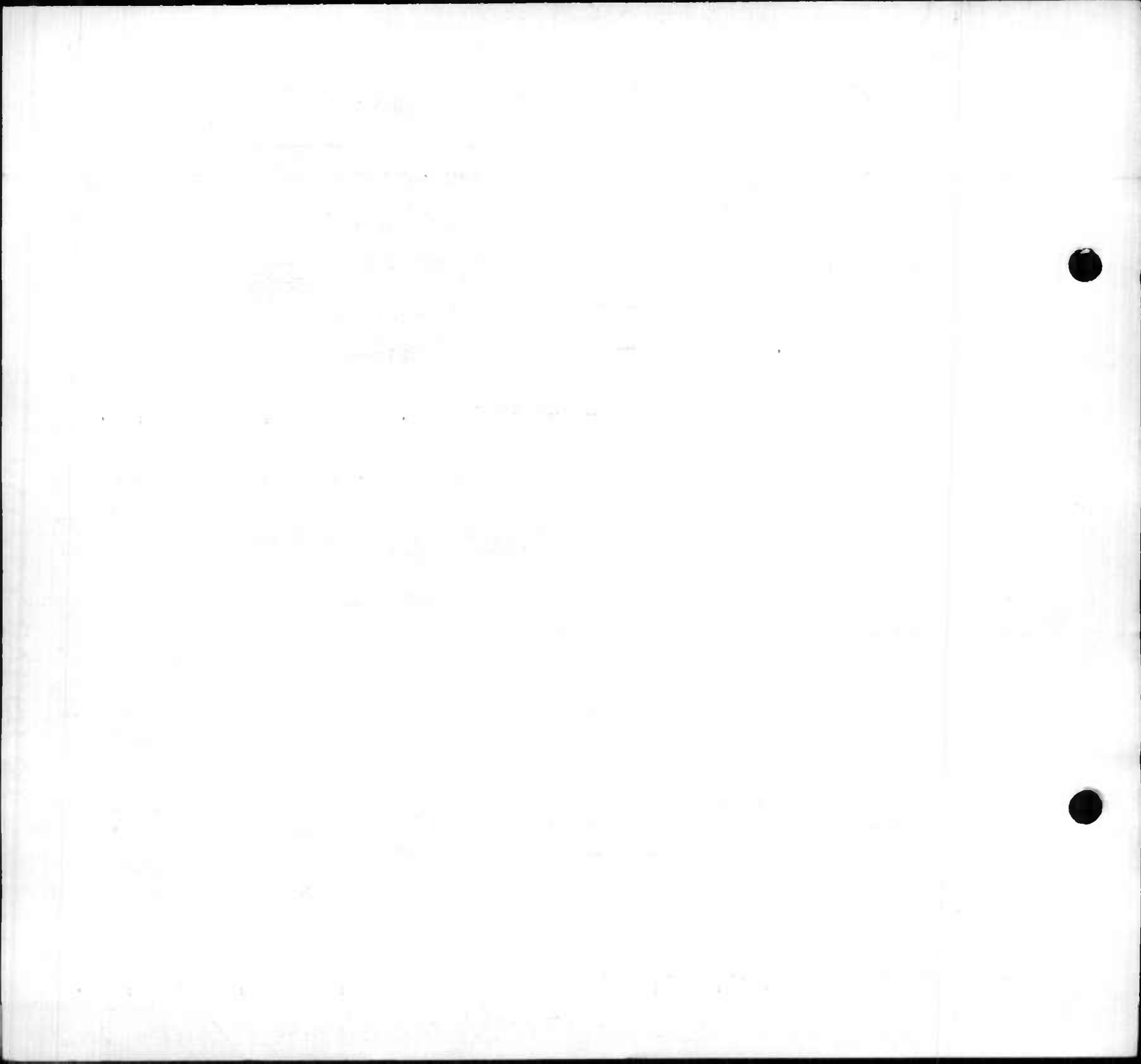
Ronald N. Kornblum, M.D.

HS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

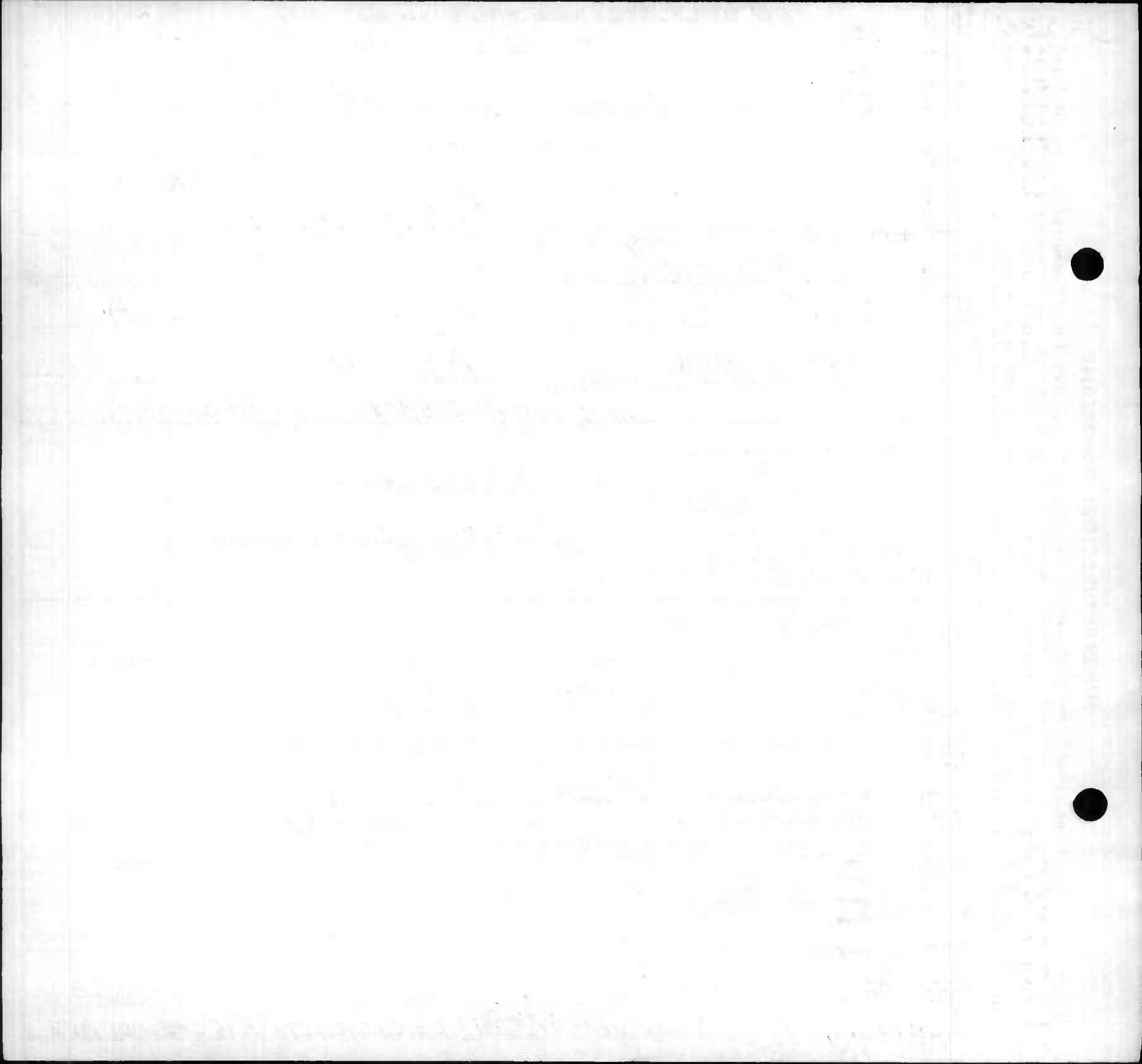
<p>D-263 72 06439</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 06439</p>	
<p>BIRTH NO. STATE OF MARYLAND-DHMH</p> <p>1. NAME OF DECEASED (Type or Print) MARGARET MAE Daugherty</p>		<p>2. DATE AND HOUR OF DEATH July 8, 1972 4:20 A M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Univ. of Md. Hosp.</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE MD. B. COUNTY Harford C. CITY OR TOWN Abingdon D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER Hook Mill Rd. RT. 1, Box 317 A</p>	
<p>5. SEX F</p>	<p>6. RACE White</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 3/29/22</p>
<p>9. AGE (In years last birthday) 50</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>	<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>
<p>12. CITIZEN OF WHAT COUNTRY? USA</p>		<p>13. FATHER'S NAME William L. Kelley</p>	
<p>14. MOTHER'S MAIDEN NAME Florence Flowers</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p>	
<p>16. SOCIAL SECURITY NO. 220-14-6867</p>		<p>17. INFORMANT ADDRESS John L. Daugherty, Abingdon, Md.</p>	
<p>18. 20721 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE Shock + Respiratory failure DUE TO, OR AS A CONSEQUENCE OF: 15 hrs.</p> <p>(B) Acute Erythromyogenous Leukemia. DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Acute Renal Shutdown</p>			
<p>19A. DATE OF OPERATION D</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from July 7, 1972 to July 8, 1972 that (I) (we) last saw the deceased alive on July 8, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE C. Thomas Folkemer M.D.</p>		<p>23B. DATE SIGNED July 8, 1972</p>	
<p>23C. PHYSICIAN'S NAME (Type) C. Thomas Folkemer M.D.</p>		<p>23D. ADDRESS Univ. of Md. Hosp., Baltimore, Md.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE July 11, 1972</p>	
<p>24C. NAME OF CEMETERY or CREMATORY Harford Memorial Gardens</p>		<p>24D. LOCATION (City, town, or county) (State) Aldino, Harford, Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972</p>		<p>25B. NAME OF REGISTRAR Sidney Weston</p>	
<p>25C. FUNERAL DIRECTOR H. H. McComas</p>		<p>ADDRESS Abingdon, Md.</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 06440</u>		
BIRTH NO. <u>72 06440</u> <u>02-21-85</u>								
1. NAME OF DECEASED (Type or Print) <u>CHARLES C. SMITH</u>				2. DATE AND HOUR OF DEATH <u>7/10/72</u> → <u>5:00</u> P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE UNION MEMORIAL HOSPITAL</u> <u>44</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MARYLAND - BALTIMORE</u>		B. COUNTY <u>1205</u>		
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER <u>3248 KESWICK RD.</u>				
5. SEX <u>M</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-85</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES C. SMITH</u>				14. MOTHER'S MAIDEN NAME <u>LAURA CARMODY</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-10-2644A</u>		17. INFORMANT <u>FLORENCE E. SMITH</u>		ADDRESS <u>3248 KESWICK RD</u>		
18. <u>569.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>G.I. BLEEDING, CARDIOV. DISEASE, AGE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION								
19A. DATE OF OPERATION <u>06/24/1972</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>G.I. BLEEDING</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.								
23A. SIGNATURE <u>Antonio J. Martins, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <u>DR. CHALLIKINDIS, M.D.</u>				23D. ADDRESS <u>803 REGESTER AVE, 21212 - BALTIMORE</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-13-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>		24D. LOCATION (City, town, or county) (State) <u>TOWSON MARYLAND</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>July 11, 1972</u>		25B. NAME OF REGISTRAR <u>Aisley Winston</u>		25C. FUNERAL DIRECTOR <u>PAUL E. CHENOWETH 3615 CHESNUT AVE.</u>				



FUNERAL DIRECTOR: IMPORTANT

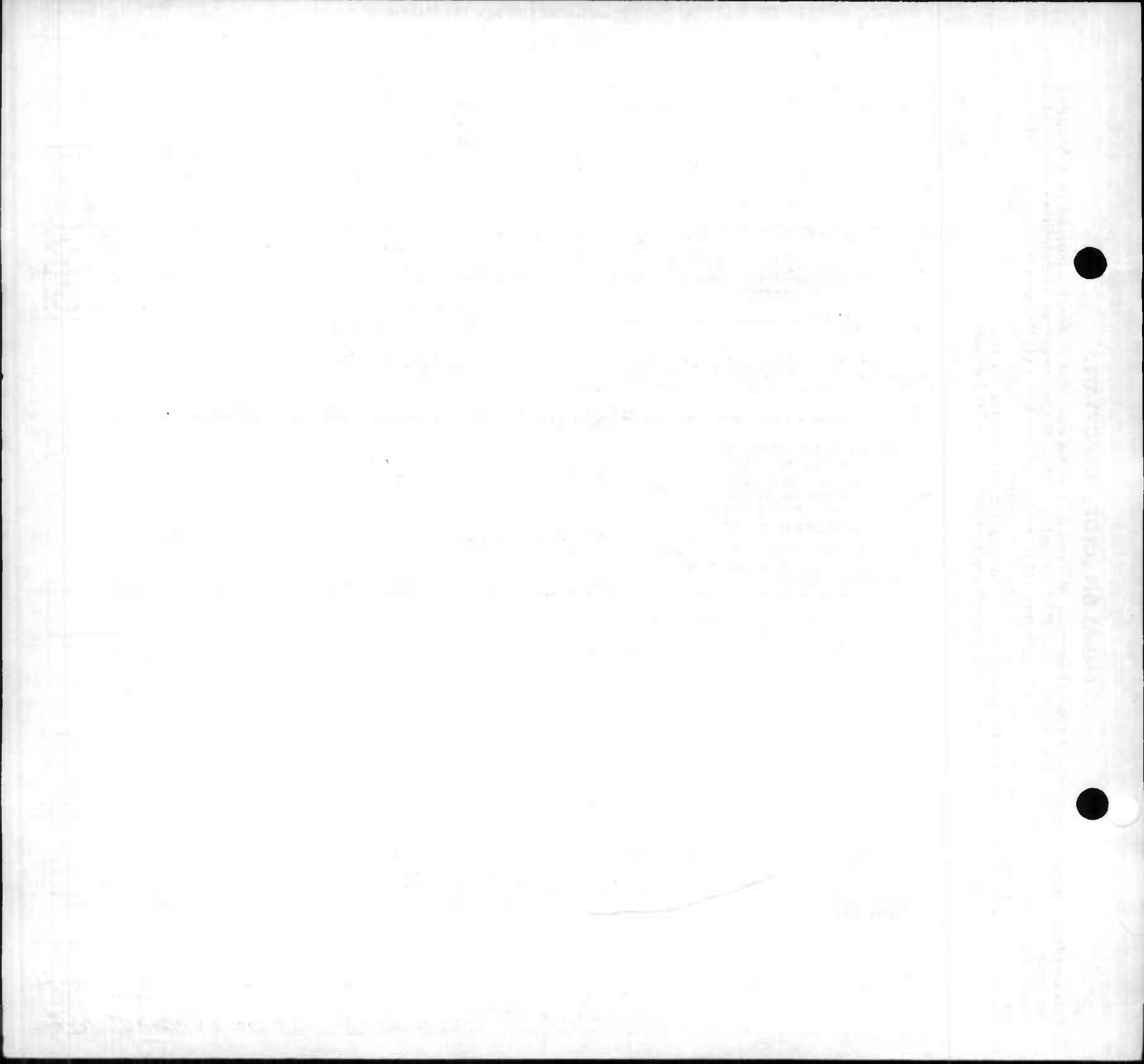
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

REG. NO. **72 06441**

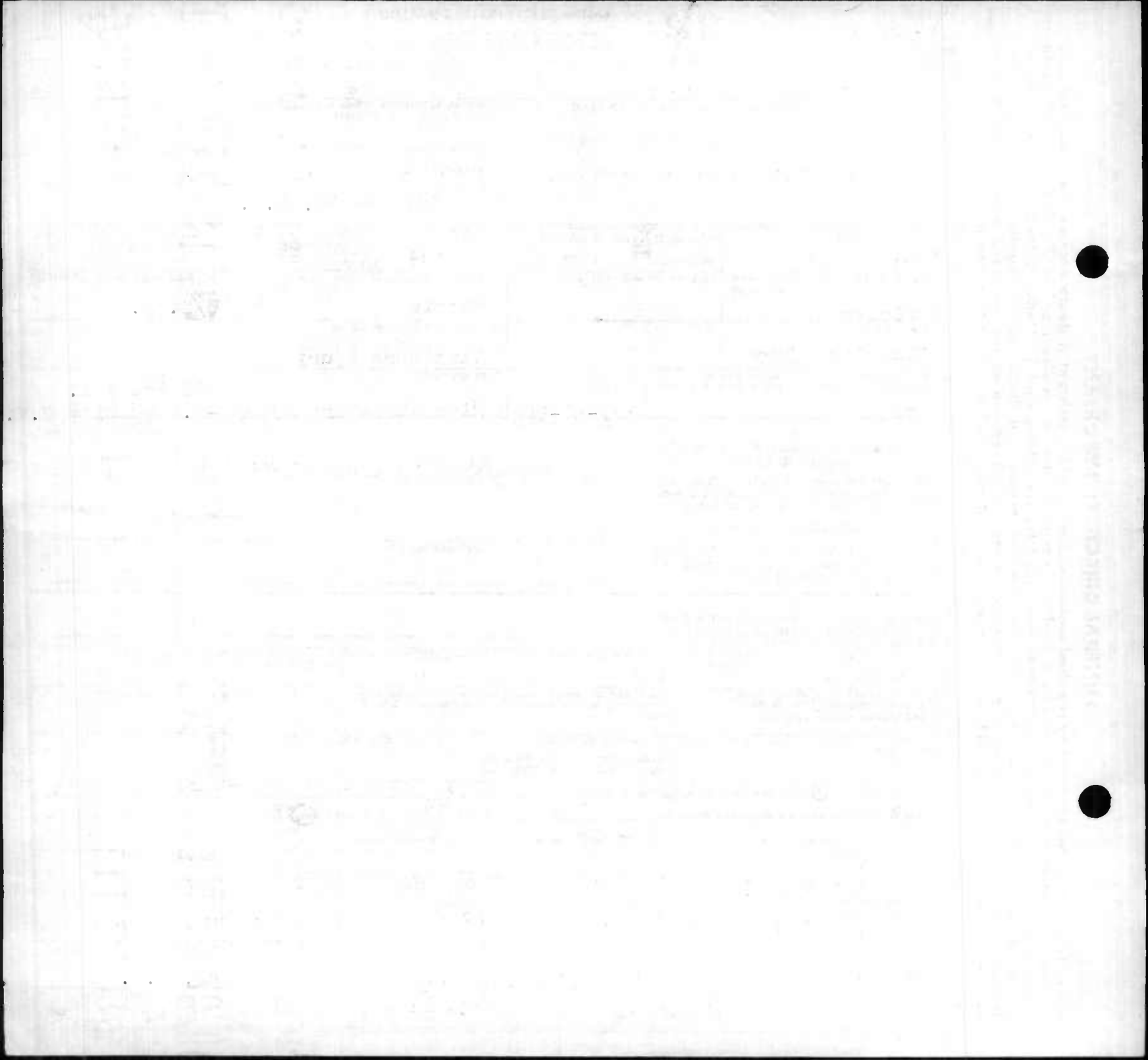
BIRTH NO. 72 06441		2. DATE AND HOUR OF DEATH 7-9-72	
1. NAME OF DECEASED (Type or Print) ANNA M. SELLMAN		M. 1207	
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL 44		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER 520 W. 27TH STREET	
5. SEX F	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-17
9. AGE (in years last birthday) 55		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME WILLIAM YINGLING		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-16-1744	
17. INFORMANT GEORGE E. SELLMAN		ADDRESS 520 W. 27TH ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.81		CAUSE OF DEATH (A) IMMEDIATE CAUSE ISCHEMIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF: (B) DIABETES MELITUS DUE TO, OR AS A CONSEQUENCE OF: (C)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION N.A.		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N.A.	
20A. AUTOPSY? (Yes or No) N.A.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N.A.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) N.A.	
21C. WHERE DID INJURY OCCUR? N.A.		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) N.A.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> N.A.	
21F. HOW DID INJURY OCCUR? N.A.			
22. I certify that (I) (this hospital) attended the deceased from 6-12 19 72 to 7-9 19 72 that (I) (we) lost saw the deceased alive on 7-9-72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Tadoshi Kuba		23B. DATE SIGNED 7-9-72	
23C. PHYSICIAN'S NAME (Type) Tadoshi Kuba		23D. ADDRESS THE UNION MEMORIAL HOSR 33rd & Calvert St. MD. Baltimore, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-13-72	
24C. NAME OF CEMETERY OR CREMATORY CEDAR HILL		24D. LOCATION (City, town, or county) (State) GLENBURNIE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. July 11, 1972		25B. NAME OF REGISTRAR Sidney Winton	
25C. FUNERAL DIRECTOR PAUL E. CHENOWETH		ADDRESS 3617 CHESNUT AVE.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 06442					REG. NO.		72 06442		
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1-260 STATE OF MARYLAND - DHMH </div> <div> CERTIFICATE OF DEATH </div> </div>									
1. NAME OF DECEASED (Type or Print) <u>Vladimir DJURY</u>					2. DATE AND HOUR OF DEATH <u>7-6-72</u> <u>805</u> <u>AM</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____				
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MARYLAND GENERAL HOSPITAL</u>					C. CITY OR TOWN <u>WASHINGTON, DC</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <u>201 Eye St. S.W.</u>				
5. SEX <u>MALE</u>		6. RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-17-13</u>		9. AGE (In years last birthday) <u>59</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		
13. FATHER'S NAME <u>Nicholas Djury</u>					14. MOTHER'S MAIDEN NAME <u>Alexandra Djury</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or date of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>127-26-9010</u>		17. INFORMANT <u>Miss Alexandra Djury</u>		
					ADDRESS <u>530 2nd Ave. N.Y.</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Adenocarcinoma of rectum</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>6-26-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Obstruction</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <u>6-22</u> <u>1972</u> to <u>7-6-</u> <u>1972</u> that (1) (we) last saw the deceased alive on <u>7-6</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Francis A. Clark Jr MD</u>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>7-6-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANCIS A. CLARK, JR</u>					23D. ADDRESS <u>112 Chase Street, Baltimore, Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>removal</u>		24B. DATE <u>7/8/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Novo Divjino cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Spring Valley, N.Y.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1972</u>		25B. NAME OF REGISTRAR <u>Ludwig H. Hinton</u>		25C. FUNERAL DIRECTOR <u>THE S.H. HINEG CO. 2901-14TH ST. N.W. WASH. D.C.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-214 72 06443		BALTIMORE CITY HEALTH DEPARTMENT		72 06443	
BIRTH NO. STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Lucy Elizabeth McFeely</u>		2. DATE AND HOUR OF DEATH <u>July 7, 1972</u> <u>7:15 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>00 3319 St. Paul St. Baltimore, Md.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1202</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3319 St. Paul Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-1886</u>	9. AGE (in years last birthday) <u>85 yrs.</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Bel Air, Maryland</u>	
13. FATHER'S NAME <u>Benjamin Smith</u>		14. MOTHER'S MAIDEN NAME <u>Smith, Lucy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>212-52-6821</u>		17. INFORMANT <u>MR WILLIAM J. MCFEELY, 8213 ROBIN AVE. TOWSON 4 Md.</u>	
18. <u>412-3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Heart failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Severe arteriosclerosis</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Heart failure</u> (B) <u>Severe arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>NO</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>NO</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>June 12</u> 19 <u>72</u> to <u>June 29</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>June 29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>DR. EDWIN J. BERSTOCK</u>		23B. DATE SIGNED <u>July 4/72.</u>		23C. PHYSICIAN'S NAME (Type) <u>302 EAST 33rd. STREET BALTIMORE, MARYLAND 21218</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 10, 1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Mount Zion Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1972</u>		25B. NAME OF REGISTRAR <u>Edwin J. Berstock</u>		25C. FUNERAL DIRECTOR <u>Frank H. Newell</u>	
25D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25E. ADDRESS <u>1202</u>			

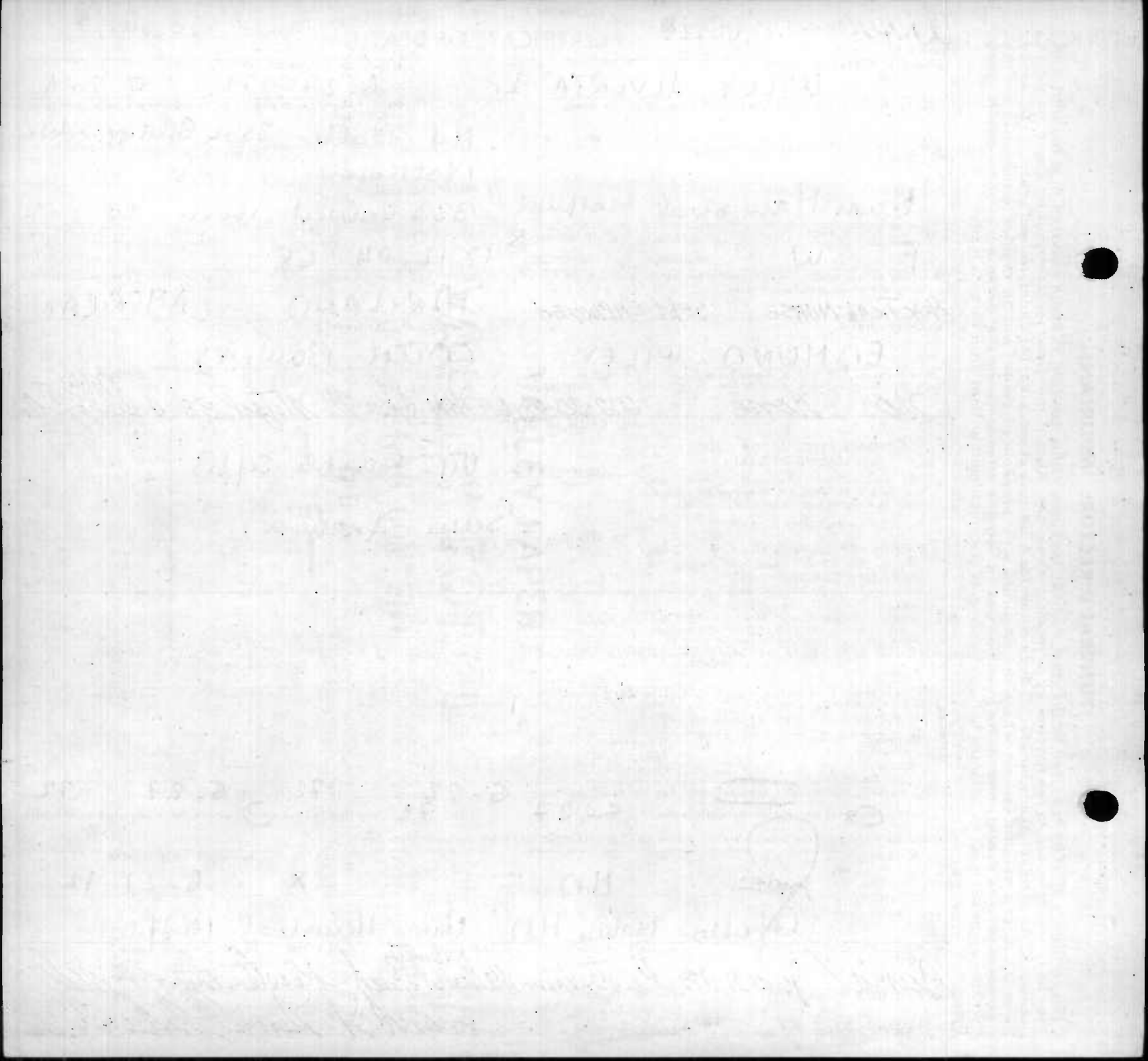
Wm. J. Burrows
Secretary

DR. EDWIN J. BERTOCK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 0644
W-400 72 0644		CERTIFICATE OF DEATH		
BIRTH NO. STATE OF MARYLAND-DEME		1. NAME OF DECEASED (Type or Print) WILEY, ALVERTA L.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 6-27-72 7.20 A.M.		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Balto C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 332 Colvert - Balto - Md 2720		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-04 9. AGE (In years last birthday) 68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL NURSE		10B. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME EDMUND WILEY		
14. MOTHER'S MAIDEN NAME EDITH BOWERS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		
16. SOCIAL SECURITY NO. 212-30-4806A		17. INFORMANT Mr. J. W. Mitzel, 3804 Blingy Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) UTI - Possible sepsis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Sever Anemia				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6-22 19 72 to 6-27 19 72 , that (I) (we) last saw the deceased alive on 6-27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]		23B. DATE SIGNED 6-27-72		
23C. PHYSICIAN'S NAME (Type) Shosson Nahas M.D.		23D. ADDRESS Union Memorial Hospital		
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE June 30, 1972		24C. NAME OF CEMETERY or CREMATORY Reisterstown
24D. LOCATION Reisterstown		25A. DATE REC'D BY HEALTH DEPT. JUN 11 1972		
25B. NAME OF REGISTRAR Friday, June 11, 1972		25C. FUNERAL DIRECTOR Frank H. Tavel, Pileville, Md.		



CHAPER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-250		72 06445		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06445	
BIRTH NO.		STATE OF MARYLAND-DEMH		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Andrew Faison				2. DATE AND HOUR OF DEATH 7-10-72 4 ³⁰ P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2003			
FULL NAME OF HOSPITAL OR INSTITUTION Md. Gen. Hosp. Inc. 48		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER John St.			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-93	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Granville Faison				14. MOTHER'S MAIDEN NAME Florence Connell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 225-16-770A		17. INFORMANT Bolton Hill Nursing Home		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHIOGENIC CARCINOMA (B) (R) LUNG, 5 FOCAL METASTASES DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days 8 Yrs 4			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-2 1972 to 7-10 1972 that (I) (we) lost saw the deceased alive on 7-10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Arnold G. Alexander MD				23B. DATE SIGNED 7-10-72			
23C. PHYSICIAN'S NAME (Type) Arnold G. Alexander MD				23D. ADDRESS 827 Linden Ave 21201			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY Mt Auburn Ct		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972		25B. NAME OF REGISTRAR Ladney Whorton		25C. FUNERAL DIRECTOR J. Brown		ADDRESS Montgomery St	

2037 Hollins St

12/21/70

7-622

72 06446

BALTIMORE CITY HEALTH DEPARTMENT

72 06446

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) WELTON H. FERGUSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 CITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour July 8, 1972 M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5/24/1914		10. AGE (In years lost birthday) 58	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		14B. KIND OF BUSINESS OR INDUSTRY Chev. Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 213-10-4685	
13. FATHER'S NAME Herbert W. Ferguson		15. MOTHER'S MAIDEN NAME Corrine E. Mc Veight	
18. INFORMANT Mrs Jacqueline A. Ferguson		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) yes	
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/9/72		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 7/12/1972		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Howard County, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972	
25B. NAME OF REGISTRAR Richard W. Hinton		25C. FUNERAL DIRECTOR ADDRESS G. Truman Schwab 5151 Balto. Nat'l. Pike	

R-152

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06447

BIRTH NO. 65-23 STATE OF MARYLAND DEATH

1. NAME OF DECEASED (Type or Print) JOSEPH ROBINSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rear of St. Paul's Cemetery		3. DATE PRONOUNCED DEAD Month Day Year Hour July 8, 1972 10:40 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9/10/1965		10. AGE (In years lost birthday) 6 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baets. Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		15. MOTHER'S MAIDEN NAME Thelma Reddick	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. -	
18. INFORMANT Thelma Robinson		ADDRESS 21223 905 Lemmon St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E968 X		CAUSE OF DEATH Blunt force injury to head	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) St. Paul's Cemetery	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 6-18-72 1:00 P.		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Angelsea and Boston Streets	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Struck on head	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/9/72			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 7/11/72	
24C. NAME OF CEMETERY or CREMATORY Crest Lawn Cem.		24D. LOCATION (City, town, or county) (State) Howard Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972		25B. NAME OF REGISTRAR Richard H. Horton	
25C. FUNERAL DIRECTOR John J. Cowan, Inc.		ADDRESS 901 Hollins St. Balt. Md. 21223	

9/10/1962
Dear Sir
Re: [illegible]

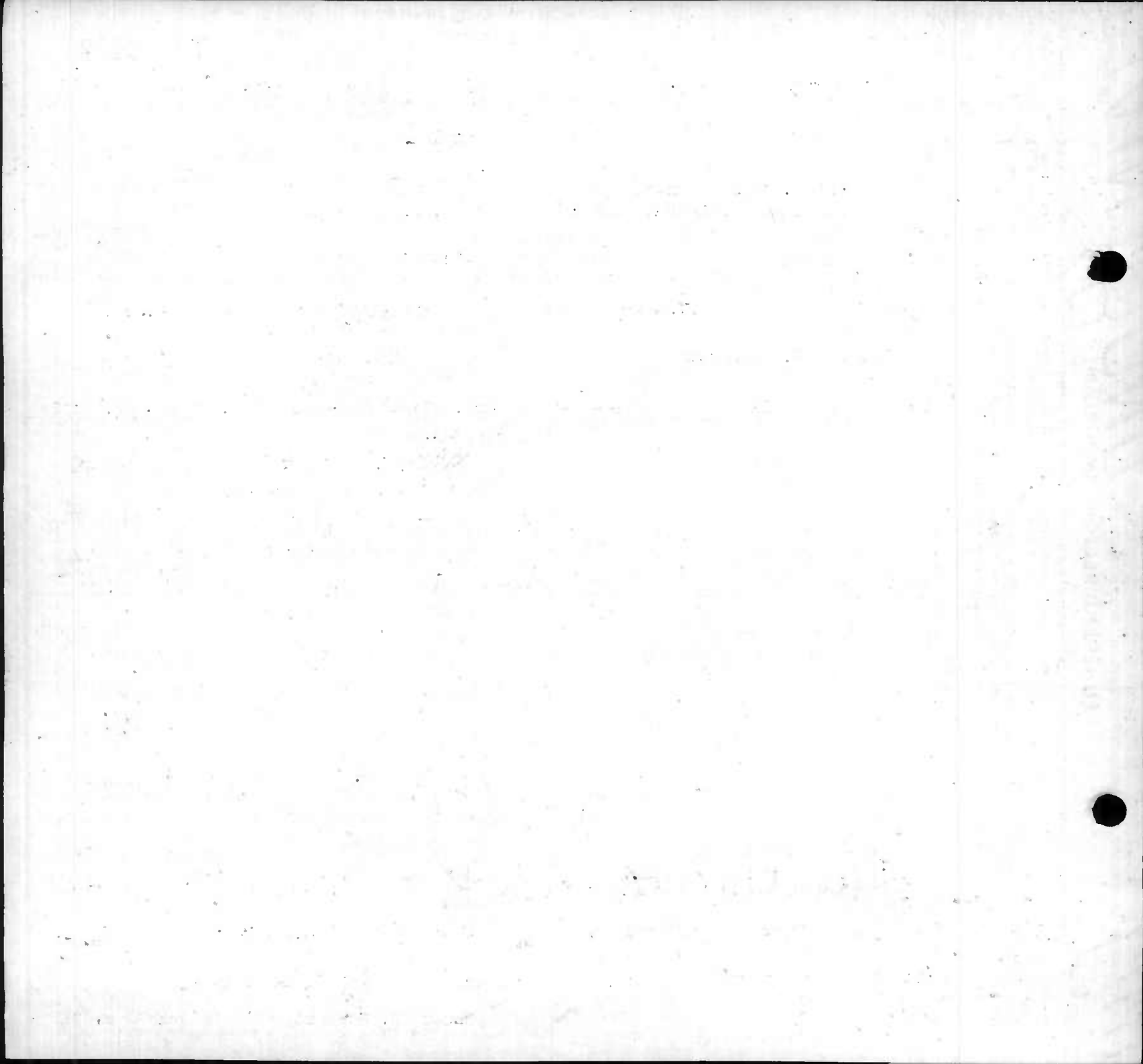
Mr. [illegible]
[illegible]
[illegible]

Yours faithfully
[illegible signature]

FUNERAL DIRECTOR: IMPORTANT

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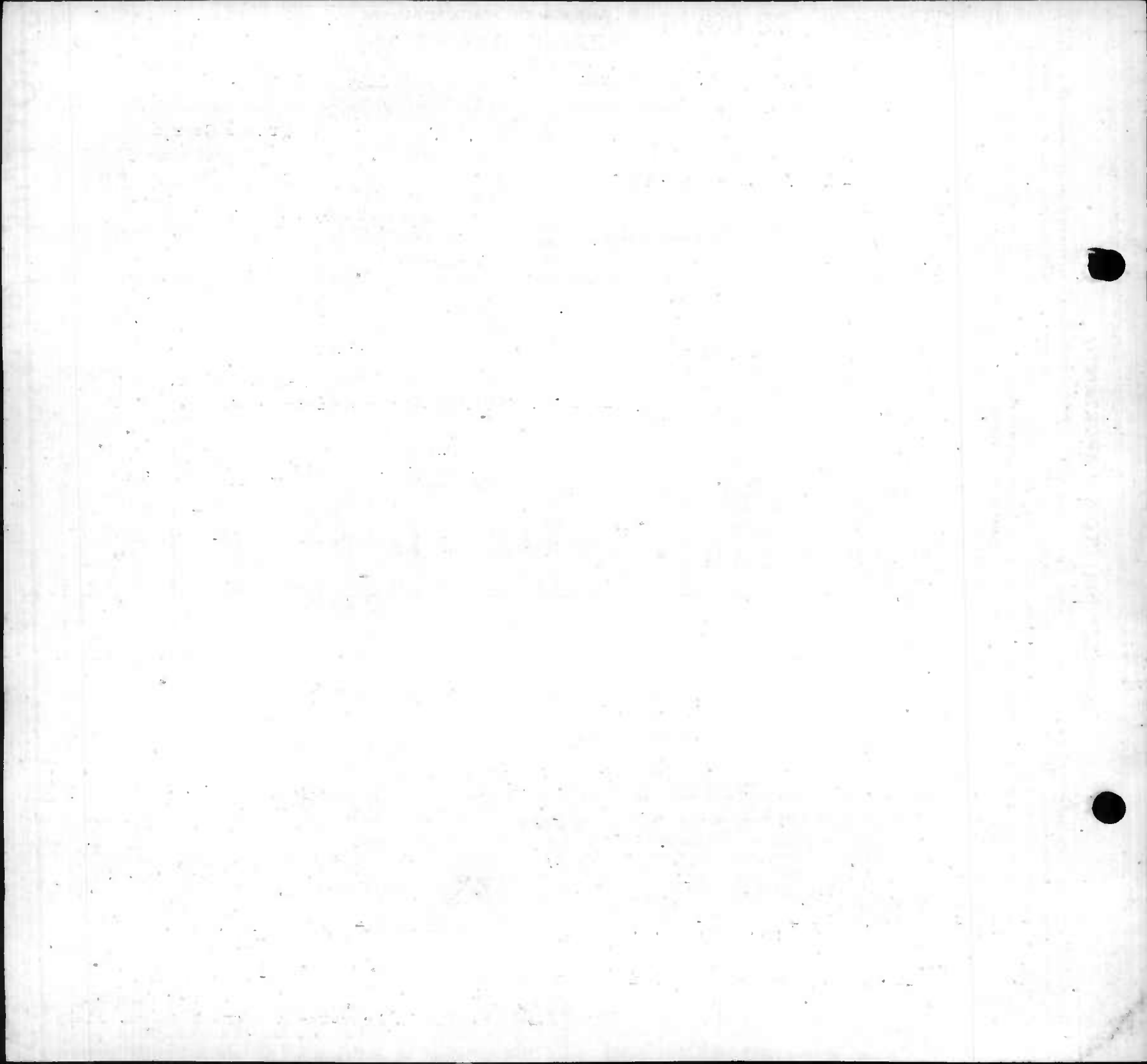
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 06448</u>	
<p>BIRTH NO. <u>K-460</u> <u>72 06448</u></p> <p>1. NAME OF DECEASED <u>OF MARYLAND-DEMD</u> (Type or Print) <u>DONALD KILROY</u></p>		<p>2. DATE AND HOUR OF DEATH <u>JULY 7, 1972</u> M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 642 S. Payson Street</u> <u>Baltimore, Maryland 21223</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2003</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>642 S. Payson Street 21223</u></p>			
<p>5. SEX <u>Male</u></p>	<p>6. RACE <u>White</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>6-22-1914</u></p>	<p>9. AGE (In years last birthday) <u>58</u></p>	<p>If Under 1 Yr. Months: <u> </u> Days: <u> </u> If Under 24 Hrs. Hours: <u> </u> Min: <u> </u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>		<p>13. FATHER'S NAME <u>William R. Baugher</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>Ida Lewis</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes W W II</u></p>			
<p>16. SOCIAL SECURITY NO. <u>214-18-4021</u></p>		<p>17. INFORMANT ADDRESS <u>Mrs. Alice Elliott, 642 S. Payson St. 21223</u></p>			
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>162.1 I Bronchogenic carcinoma</u></p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>of the lungs</u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(B) Malignant metastatic disease</u></p>		<p>(C) Anemia</p>		<p><u>months</u></p>	
<p>II</p>					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <u> </u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u></p>		<p>20A. AUTOPSY? (Yes or No) <u> </u></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u> </u></p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u></p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u> </u></p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u> </u></p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? <u> </u></p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>May 18/1972</u> to <u>July 7/1972</u> that (I) (we) last saw the deceased alive on <u>July 7/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after-death.</p>					
<p>23A. SIGNATURE <u>Henry Armanas</u></p>		<p>23B. DATE SIGNED <u>July 10, 1972</u></p>		<p>23C. PHYSICIAN'S NAME (Type) <u>Henry Armanas</u></p>	
<p>23D. ADDRESS <u>1934 Wilkens Avenue, Baltimore, Maryland</u></p>		<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>			
<p>24B. DATE <u>7-10-1972</u></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>Lisley Thornton</u></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 06449</u>	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Phillip H. Reinhardt</u>		CERTIFICATE OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>		2. DATE AND HOUR OF DEATH <u>July 7, 1972</u>			
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>10-13-07</u>	
13. FATHER'S NAME <u>Reinhardt</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		9. AGE (In years last birthday) <u>64</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-9774</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Atherosclerosis</u> (C)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
19A. DATE OF OPERATION <u>7/10/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 1952</u> to <u>7/7</u> 19<u>72</u>, that (I) (we) last saw the deceased alive on <u>May 15</u> 19<u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John C. Healy M.D.</u>				23B. DATE SIGNED <u>7/9/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>John C. Healy M.D.</u>				23D. ADDRESS <u>1311 Francis Avenue, Balto., Md. 21227</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-11-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1972</u>		25B. NAME OF REGISTRAR <u>Andrew H. Hubbert</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard-4107 Wilkens Ave. 21229</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 06450	
CERTIFICATE OF DEATH				REG. NO. _____	
1. NAME OF DECEASED (Type, or Print) Martha Little		2. DATE AND HOUR OF DEATH July 9, 1972 12:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION George Washington Nursing Home 607 PENNSYLVANIA AVE BALTIMORE, MD 21202		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1356 Cleveland St			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/02	9. AGE (in years last birthday) 70	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE		CAUSE OF DEATH HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROSIS			
		(B) DUE TO, OR AS A CONSEQUENCE OF: LEFT HEMIPLEGIA			
		(C) HYDROCEPHALOSIS SENILITY			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6-30-1972 to 7-9-1972 that (1) (we) last saw the deceased alive on 7-9-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard Tyson, M.D.		23B. DATE SIGNED 7-9-72		23C. PHYSICIAN'S NAME (Type) Dr. Richard Tyson, M. D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/15/72		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972			
25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave			

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2

72 06451		BALTIMORE CITY HEALTH DEPARTMENT		72 06451	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. <u>M-240</u>		STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) HELEN MICKLE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 10, 1972 8:45 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 560 W. Preston Street		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1702		6. SEX Female 7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 1936		10. AGE (In years last birthday) 36		E. STREET AND NUMBER 560 W. Preston Street	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Cleland Method	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Berneice	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Mrs Mary James, 403 Mt Holly St	
19. E966 IX		CAUSE OF DEATH Stab wounds of Back		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 7/15/72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 562 W. Preston Street	
22D. TIME OF INJURY (APPROX.) 7-10-72 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. DATE SIGNED 7/11/72 EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL Buried		24B. DATE 7/15/72		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town or county) (State) Baltimore Md		24E. NAME OF REGISTRAR M. Auburn Cemetery		24F. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972		25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	

WALKER & POLLOCK

1		72 06452		BALTIMORE CITY HEALTH DEPARTMENT		72 06452	
H-155		72 06452		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
BIRTH NO.		STATE OF MARYLAND - DIME					
1. NAME OF DECEASED (Type or Print)		IRENE HUFFMAN		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month Day Year Hour July 7, 1972 2:30 P. M.	
44 UNION MEMORIAL HOSPITAL				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE B. COUNTY	
				Maryland		1206	
6. SEX	7. RACE	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Female	White			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday)		E. STREET AND NUMBER			
1/23/06		66		2024 N. Charles Street			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
Pennsylvania		USA		--- WALLACE			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
housewife				unknown			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
no		220-14-9967		Bath A. Huffman (husb)		2024 N. Chas. St.	
19. 4210		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Subacute bacterial endocarditis with pulmonary and renal infarcts					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE					
		DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		Bilateral bronchopneumonia					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C) DUE TO, OR AS A CONSEQUENCE OF:					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
2				yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type)		Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		7/8/72	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial		7/10/72		Glen Haven		Gov. Ritchie Hgy, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 12 1972		Society for Health		Leonard J. Ruck, Inc. - Balto, Md.			

WATLEY MOI

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06453
D-650 STATE OF MARYLAND-DEPT. OF HEALTH		P. CERTIFICATE OF DEATH		
BIRTH NO. 72 06453		1. NAME OF DECEASED (Type or Print) ALEXANDER DERON		
2. DATE AND HOUR OF DEATH JULY 8/1972 7:00 A M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 903		5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
6. STREET AND NUMBER 3627 GREENMOUNT AVE.		7. SEX M 8. RACE W 9. MARIED <input checked="" type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Engineer		10. B. DATE OF BIRTH JUNE 13/1985 9. AGE (In years last birthday) 87		
11. BIRTHPLACE (State or foreign country) Belgium		12. C. CITY OR WHAT COUNTRY? Belgium		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-05-0140		17. INFORMANT ADDRESS Chas. Deva ud 2702 Southern Ave.
18. 44441 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSED - RESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ARREST		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SENILITY - AND ACUTE (B)		20. DUE TO, OR AS A CONSEQUENCE OF: FEVERED PULMONARY VASCULAR OCCULTION		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). SPONTANEOUS PULMONARY ARREST				
22. DATE OF OPERATION JULY 7/1972		23. CONDITION FOR WHICH OPERATION WAS PERFORMED acute pulmonary (B) occlusion		24. AUTOPSY? (Yes or No)
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
28. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		29. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		30. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from JULY - 6 - 10 1972 to JULY 8 1972, that (I) (we) last saw the deceased alive on JULY 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]		23B. DATE SIGNED JULY 8/1972		23C. PHYSICIAN'S NAME (Type) HOWARD F. SEKEEL
24A. BURIAL CREMATION, REMOVAL (Specify) Crementation		24B. DATE 7/11/72		24C. NAME OF CEMETERY or CREMATORY Greenmount
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972		
25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.		

THE UNIVERSITY OF CHICAGO

IN THE

OFFICE OF THE

CHANCELLOR

CHICAGO, ILLINOIS

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CHICAGO, ILLINOIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

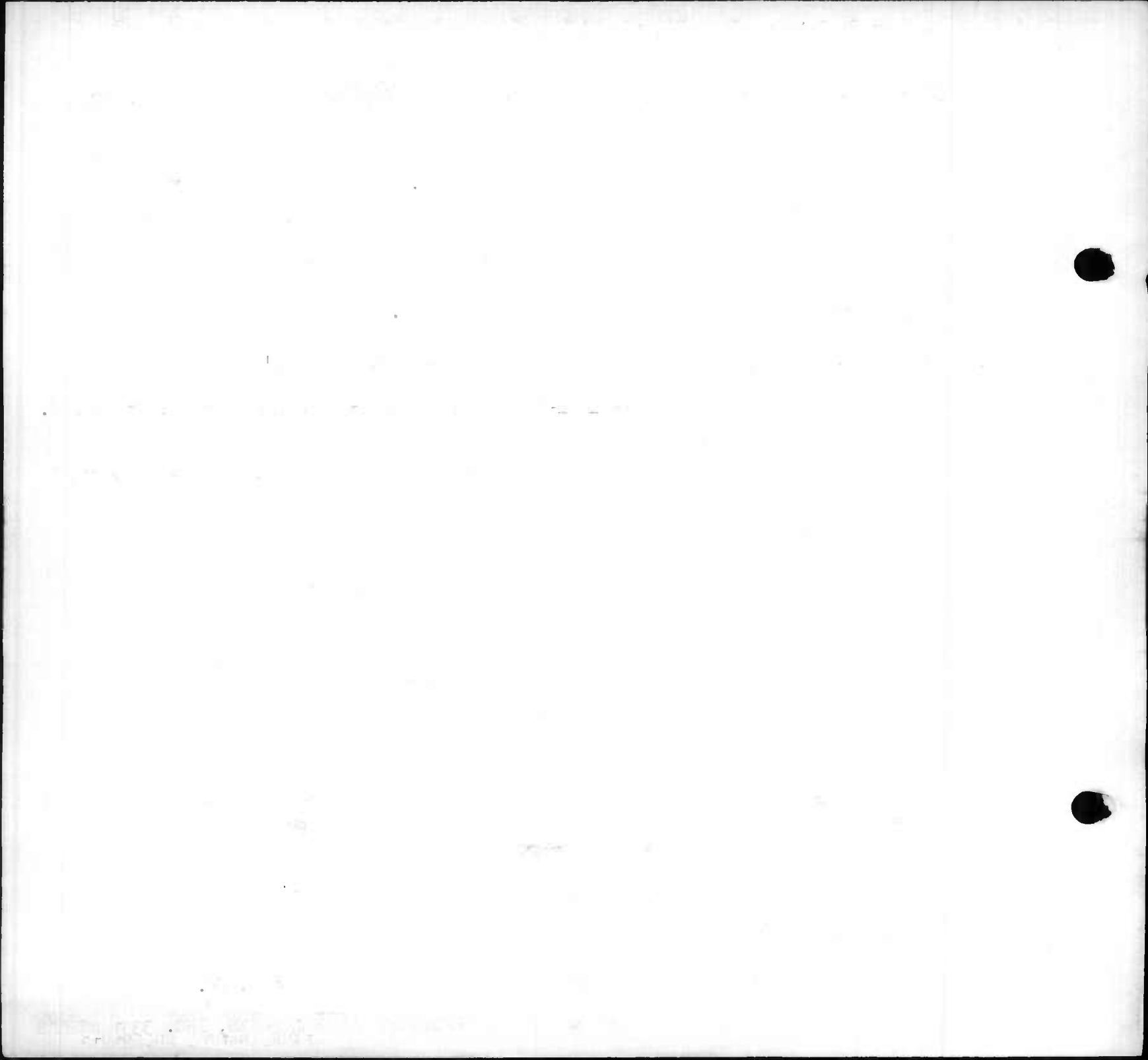
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06454	
S-625 - 72 06454				CERTIFICATE OF DEATH	
BIRTH NO. 72 06454		STATE OF MARYLAND - DEPT.			
1. NAME OF DECEASED (Type or Print) SARGENT, FLORENCE Iola			2. DATE AND HOUR OF DEATH 7/8/72 1:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Melchior Nursing Home 2643		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital 44 33rd + Calvert Streets Balt. Md. 21218			C. CITY OR TOWN Balt. Md. 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female		6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-98	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balt. Md.	
12. CITIZEN OF WHAT COUNTRY? United States			13. FATHER'S NAME Robert A. Gibson		
14. MOTHER'S MAIDEN NAME Lizzie Henson			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 232-50-6424		17. INFORMANT ADDRESS Roy Pauley (son) 3717 Elmley Ave.			
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis Diabetes mellitus. (C) _____		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/5 1972 to 7/8 1972, that (I) (we) last saw the deceased alive on 7/8 1972 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Alan N. Lieberman STUART D. SUDDAY ALAN N. LIEBERMAN				23B. DATE SIGNED 7/8/72	
23C. PHYSICIAN'S NAME (Type) ALAN N. LIEBERMAN				23D. ADDRESS Union Memorial Hospital, Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Transit		24B. DATE 7/12/72		24C. NAME OF CEMETERY or CREMATORY Sunset Memorial Park	
24D. LOCATION (City, town, or county) (State) Kanawha Co., W. Va.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Schimmek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213		25C. FUNERAL DIRECTOR ADDRESS			

3717 Elmley Ave
5/1/72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

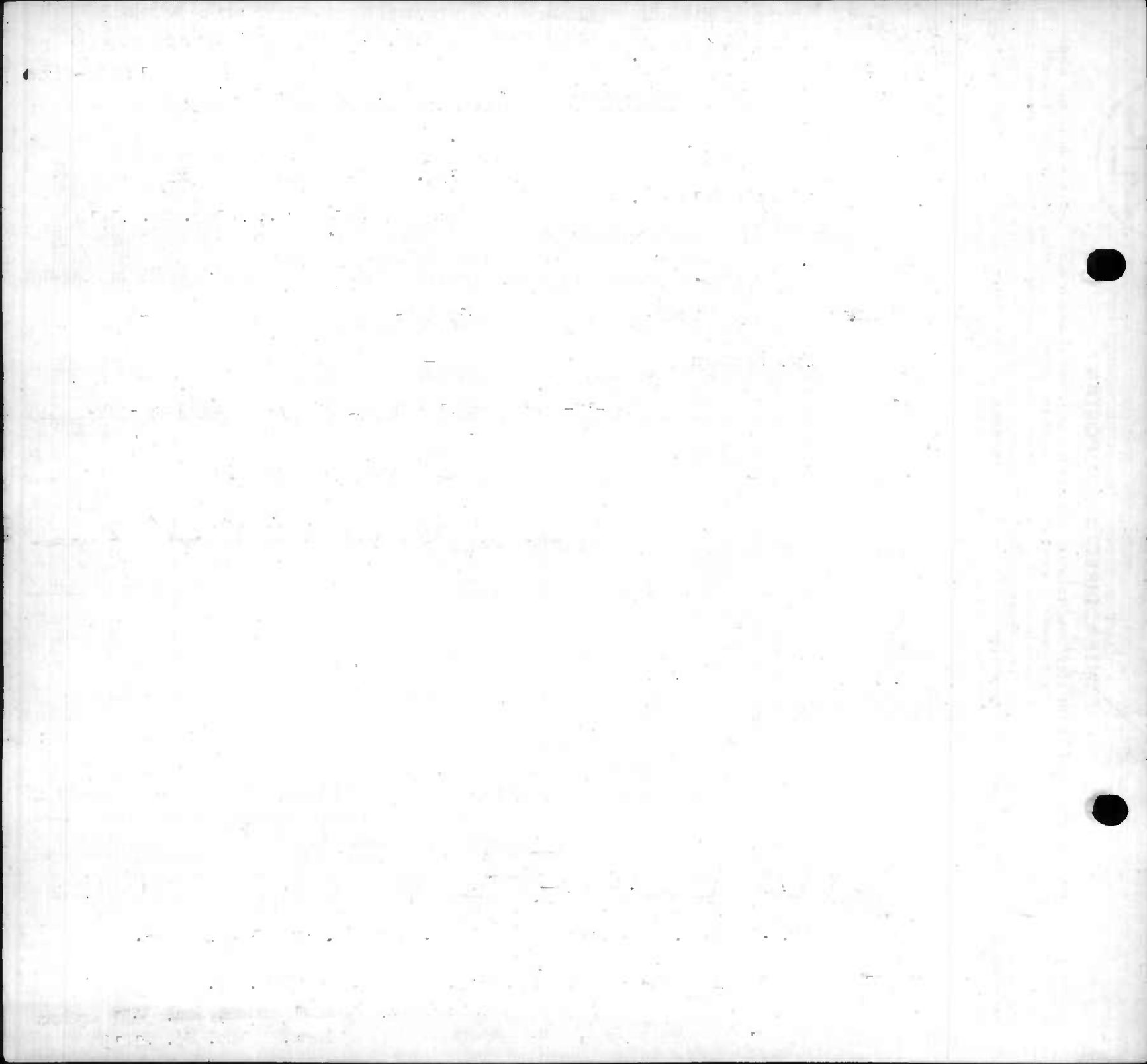
S-362		72 06455		BALTIMORE CITY HEALTH DEPARTMENT		72 06455	
CERTIFICATE OF DEATH				REG. NO. _____			
1. NAME OF DECEASED (Type or Print) STRECKFUS, MARIE MARGARET				2. DATE AND HOUR OF DEATH 7/6/72 2 30 PM <small>M.</small>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 841			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND 8 HOSPITAL				C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3117 MARECO AVENUE			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/11/01	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME HANS W. BOEBEL				14. MOTHER'S MAIDEN NAME MARGARET O'BRIEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-07-1882		17. INFORMANT John Boehel (brother) ADDRESS 4207 Hamilton Ave.	
18. 199.01 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF: MONTHS			
				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____ DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 6/14 19 72 to 7/6 19 72 that (we) last saw the deceased alive on 7/6 19 72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE James E. Mouldsdale M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/6/72	
23C. PHYSICIAN'S NAME (Type) JAMES Mouldsdale MD				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/10/72		24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972		25B. NAME OF REGISTRAR Lidney Whitson		25C. FUNERAL DIRECTOR SCHMUNKER FUNERAL HOMES, INC.		ADDRESS 3331 BREHMS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 66456</u>	
BIRTH NO. <u>4-255</u>		72 66456		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>PAUL EDWIN HOCKMAN</u>			2. DATE AND HOUR OF DEATH <u>7/6/72</u> <u>12 mid-night</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4506 Mainfield Ave.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2702</u>		
			C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4506 Mainfield Ave., Balto. Md. 21214</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/7/05</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sachs & Sons</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Jacob Hockman</u>			14. MOTHER'S MAIDEN NAME <u>-</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>226-78-2745</u>		17. INFORMANT <u>Mabel Hockman (wife)</u>	
				ADDRESS <u>same as above</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>146.8 I</u> <u>Carcinoma metastatic</u> <u>Ca of Bronchial cleft cyst</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma metastatic</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Ca of Bronchial cleft cyst</u> (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): <u>0</u>					
19A. DATE OF OPERATION <u>01970</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>170</u> 19 <u>7-7-72</u> to <u>7-7-72</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Albert W. Montague</u>				23B. DATE SIGNED <u>7-7-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Albert W. Montague</u>				23D. ADDRESS <u>5820 York Rd. nr Belvedere Ave.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/10/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>	
				ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 72 06457	
B-430 72 06457							
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <u>Belt</u> <u>Bertha M</u>				2. DATE AND HOUR OF DEATH <u>7-9-72</u> <u>7:35 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Hamilton Nursing Center</u> <u>6040 Harford Rd. Balto. Md</u>				A. STATE <u>Md.</u>		B. COUNTY <u>BALTO</u> <u>5300</u>	
				C. CITY OR TOWN <u>Louisa Md.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>29 E. Burke Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-84</u>	9. AGE (In years last birthday) <u>88</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Ambrose</u>				14. MOTHER'S MAIDEN NAME <u>Phoebe C. Cox</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-5531</u>		17. INFORMANT <u>Dorothy L. Barton</u>		ADDRESS <u>21204</u>	
						<u>29 Burke Ave. Balto. Md.</u>	
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarct.</u>			
				(B) <u>HASCD with cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>1/19</u> 19 <u>72</u> to <u>7/9</u> 19 <u>72</u> , that <u>he</u> (we) last saw the deceased alive on <u>7/4</u> 19 <u>72</u> and that in (my) <u>my</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>I. W. Fromm, M.D.</u>				OEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7/10/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>I. W. Fromm, M.D.</u>				23D. ADDRESS <u>8014 Old Harford Rd. Balto Md. 21234</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/11/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Salem Methodist Church Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Upper Falls Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Johnson</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd. Balto. 21236</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 06458	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. <u>S-246-72 06458</u>		STATE OF MARYLAND-DEPT. OF HEALTH		DATE AND HOUR OF DEATH <u>July 6, 1972</u> <u>11:00</u> AM	
1. NAME OF DECEASED (Type or Print) <u>Wilma Sickler</u>		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-5-55</u> 9. AGE (in years last birthday) <u>17</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Cleveland Oxendine</u>	
14. MOTHER'S MAIDEN NAME <u>Sickler, Jean L.</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT (Mother) <u>7838 St. Boniface Lane</u> <u>Mrs. Jean L. Chavis, Dundalk, Md. 21222</u>		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EMBOLUS</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (SUSPECTED)		<u>1 HOUR</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>POST OPERATIVE THROMBOPHLEBITIS</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:		<u>6 DAYS.</u>	
<u>CONGENITAL HEART DISEASE</u>		(C)		<u>BIRTH</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6/30/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PREGNANCY</u>		20A. AUTOPSY (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>0</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>0</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>0</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>0</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>6/30</u> 19 <u>72</u> to <u>7/6</u> 19 <u>72</u> that (2) (we) last saw the deceased alive on <u>7/6</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kevin B. Schaber</u>		23B. DATE SIGNED <u>7/6/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Kevin B. Schaber, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/10/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Park</u>	
24D. LOCATION (City, town, or county) <u>Dorsey, Maryland</u>		24E. ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>		24F. FUNERAL DIRECTOR <u>John J. Duda</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1972</u>		25B. NAME OF REGISTRAR <u>Ludwig H. H. H.</u>		25C. ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>	

James Hopkins Hospital

Room 24

3-2-33

1933

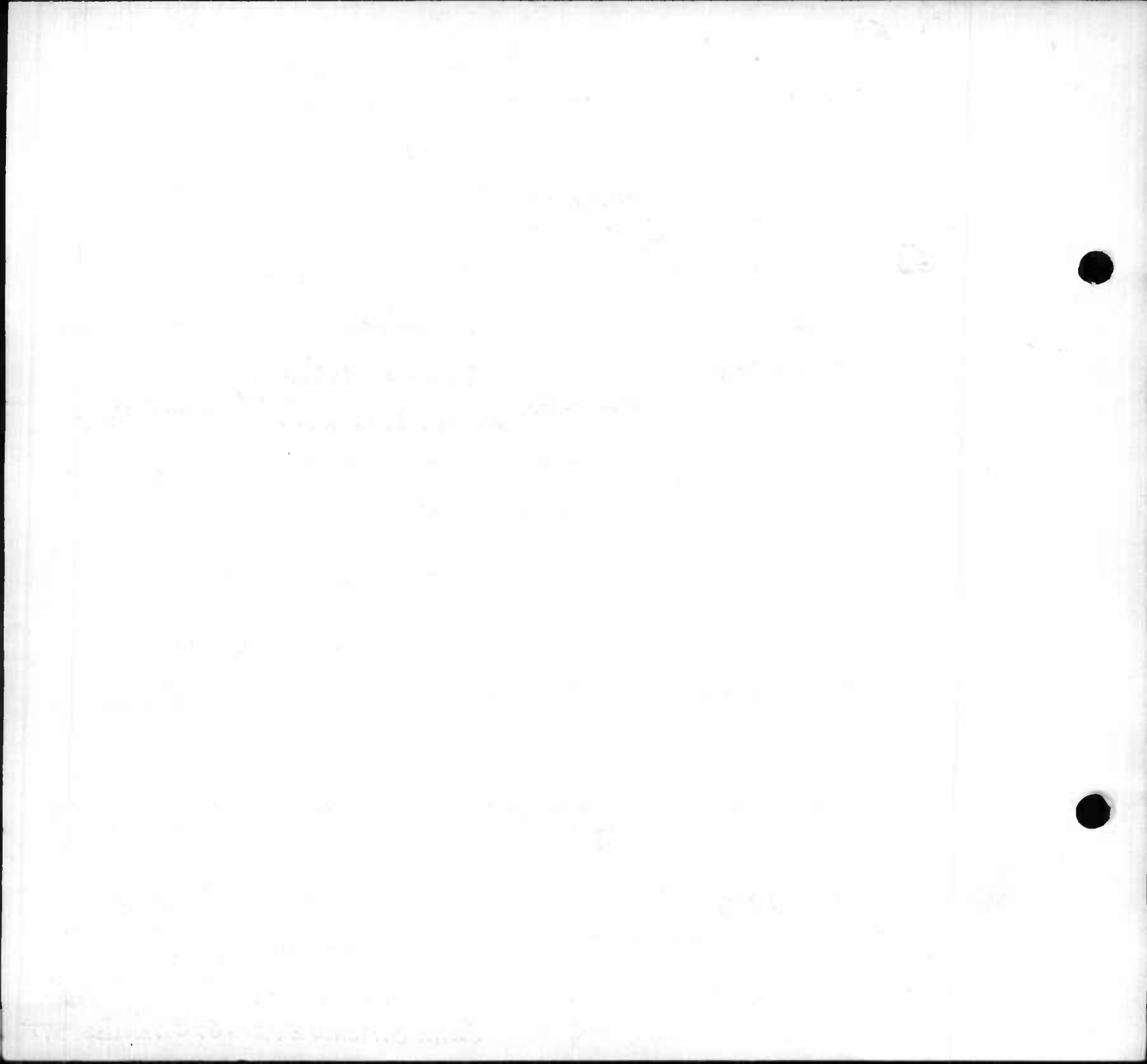


July 2, 1933



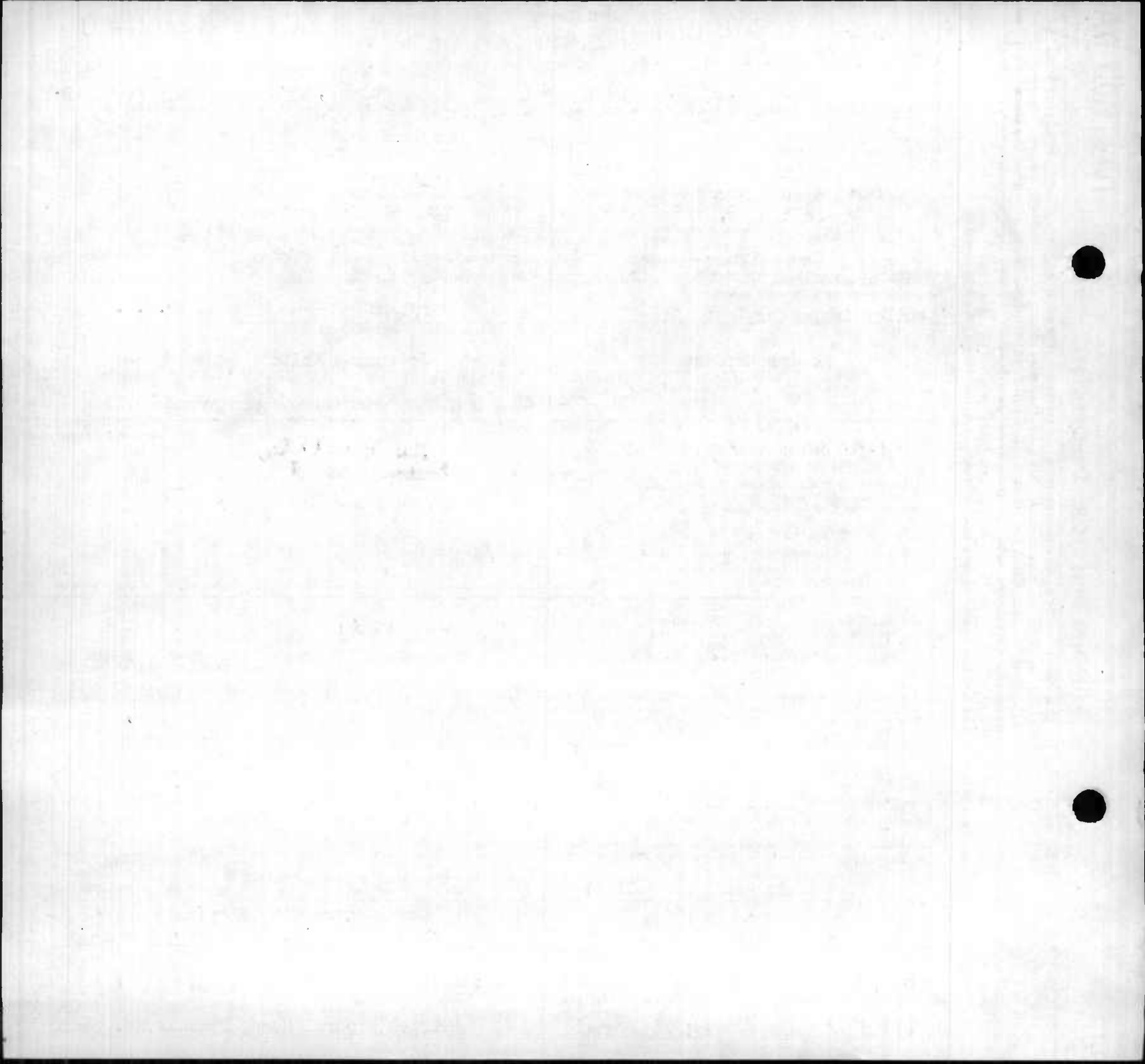
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 06459 STATE OF MARYLAND - DEPT. OF HEALTH CERTIFICATE OF DEATH				REG. NO. 72 06459	
1. NAME OF DECEASED (Type or Print) OFFENBACKER BEATRICE, C			2. DATE AND HOUR OF DEATH 7/9/72 12:05 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 MARYLAND LUTHERAN HOSPITAL OF (BALTIMORE)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2102		
5. SEX F 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			E. STREET AND NUMBER 1165 W. Hamburg St.		
10B. KIND OF BUSINESS OR INDUSTRY			8. DATE OF BIRTH 11-27-21 9. AGE (In years lost birthday) 50		
13. FATHER'S NAME ELLIOTT LOVERN			11. BIRTHPLACE (State or foreign country) VIRGINIA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME NELLIE WILSON		
16. SOCIAL SECURITY NO. 234-28-3321			12. CITIZEN OF WHAT COUNTRY? AMERICA		
18. 560.91 + 182.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Respiratory failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 1) PNEUMONITIS 2) INTESTINAL OBSTRUCTION		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(B) DUE TO, OR AS A CONSEQUENCE OF: 3) CANCER OF UTERUS - Post		
19A. DATE OF OPERATION 6/25/72			(C) 12 RADIATION 4) NECROSIS - ABDOMINAL WOUND		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION			20A. AUTOPSY? (Yes or No) NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 26 1972 to July 4 1972 that (I) (we) last saw the deceased alive on July 9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE RENATO A. LABOG			23B. DATE SIGNED 7/9/72		
23C. PHYSICIAN'S NAME (Type) RENATO A. LABOG			23D. ADDRESS LUTHERAN HOSPITAL BALTO MD		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE July 12-72		
24C. NAME OF CEMETERY or CREMATORY CEDAR HILL			24D. LOCATION (City, town, or county) (State) RITCHIE HWY AAACOUNTY MD		
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972			25B. NAME OF REGISTRAR DORIS S. KRAUSE		
25C. FUNERAL DIRECTOR DORIS S. KRAUSE			ADDRESS 1216 S. CHARLES ST		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		STATE OF MARYLAND - DH		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		Mardaga, Thomas		2. DATE AND HOUR OF DEATH		July 9, 1972		5:00 p. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		BALTO 5300	
BCH				Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER		7402 Blevins Avenue	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
Male		Caucasian		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		3/8/93		79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
boiler inspector				Steel		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Adolph Mardaga				Josephine White					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no				213-09-1589		BCH RECORDS: 4940 Eastern Avenue 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last:				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2						Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6-12 19 72 to 7-9 19 72, that (I) (we) last saw the deceased alive on 7-7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE								23B. DATE SIGNED	
J. Anderson MD									
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS	
John Anderson								Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
cremation		12 July 72		Green Mount Crematorium		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUN 12 1972				Sidney H. Hinton		Ullrich Funeral Home, Dundalk, Md. 21222			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06461
BIRTH NO. 72 06461		STATE OF MARYLAND-DHMH CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) William Presley Johnson		2. DATE AND HOUR OF DEATH July 9 1972 1 5 45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 48 Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1702		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9-28-97		9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harry Johnson		14. MOTHER'S MAIDEN NAME Pinkney Warren		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Walter Johnson
18. 4/2.4/ DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiorespiratory Failure (?)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Malnutrition; Sepsis (?)				
19A. DATE OF OPERATION NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
20B. (IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 501 Dolphin St.
21D. TIME OF INJURY (APPROX.) - 7-9-72 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL ON FLOOR
22. I certify that (I) (this hospital) attended the deceased from July 9 1972 to 5:45 PM 19 72 and that (I) (we) last saw the deceased alive on July 9 1972 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Mallari		23B. DATE SIGNED 7/9/72		
23C. PHYSICIAN'S NAME (Type) RAYMUNDO T. MALLARI MD		23D. ADDRESS MGH 827 LINDEN AVE.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-12-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State) Balto., Md.				
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972		25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR V. Bailey
25D. ADDRESS Kelson F.H. 1348 Calhoun Street				

HP PP-8E-P

h77

4.2.6

1. NAME OF DECEASED (Type or Print) GAZELLE GARNER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1222 Druid Hill Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour July 10, 1972 6:50 P. M.		
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1702		
7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. DATE OF BIRTH 8-1-07		10. AGE (In years last birthday) 64 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		
17. SOCIAL SECURITY NO.		18. INFORMANT (son) ADDRESS Kermit Carter 1212 Druid Hill Ave.		
MEDICAL CERTIFICATION		19. 412.21 CAUSE OF DEATH Hypertensive cardiovascular disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21. AUTOPSY? (Yes or No) no				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, allice bldg., etc.)		
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22F. HOW DID INJURY OCCUR?				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 7/11/72				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-72		
24C. NAME OF CEMETERY or CREMATORY Family Plot		24D. LOCATION (City, town, or county) (State) Lancaster Co., Va.		
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972		25B. NAME OF REGISTRAR Andrew M. Brown		
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 Calhoun Street		

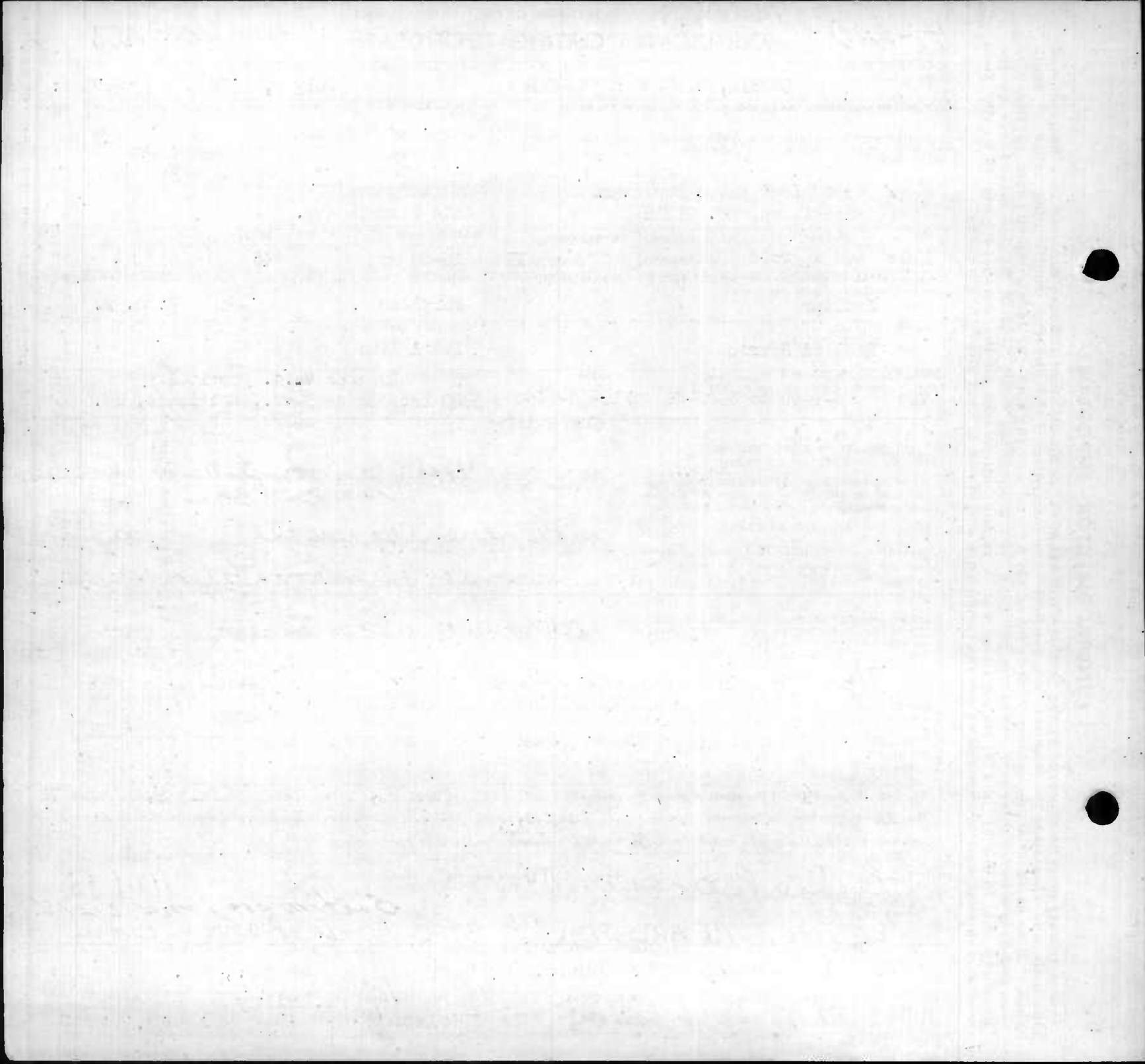
WALTER V. BOLE

ROYAL CANADIAN MOUNTED POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

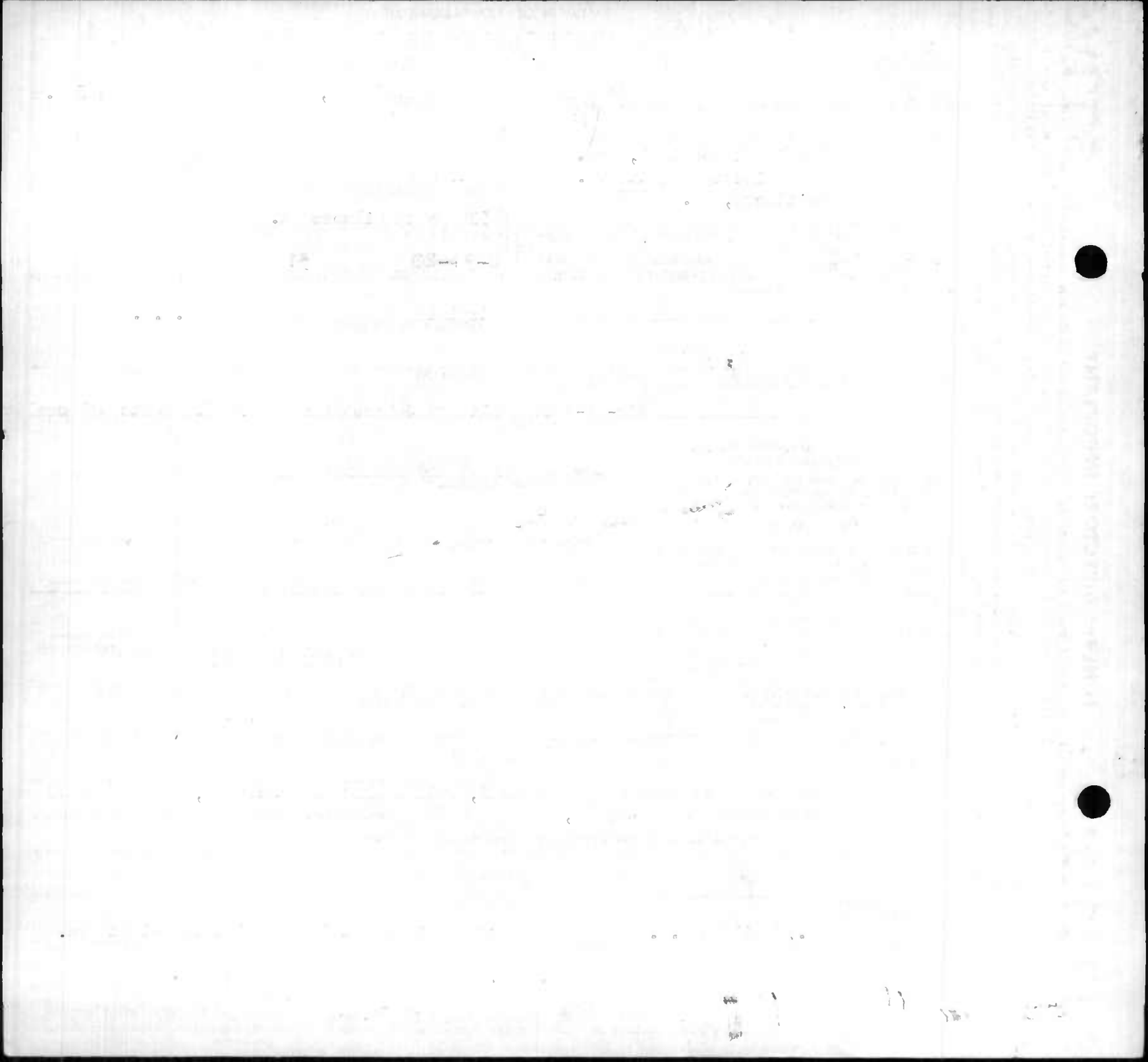
BIRTH NO. 72 06463		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06463
1. NAME OF DECEASED (Type or Print) HARRIS, RICHARD SYLVESTER		2. DATE AND HOUR OF DEATH July 9, 1972 4:25 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Md. 21218		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male 6. RACE Negroid 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-20-25		9. AGE (In years last birthday) 46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Richard Harris		
14. MOTHER'S MAIDEN NAME Pearl Sims		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 2-3-44 to 8-26-46		
16. SOCIAL SECURITY NO. 219-18-7450		17. INFORMANT Records V.A. Hospital ADDRESS 3900 Loch Raven Blvd., Baltimore, Md.		
18. 303.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Upper Gastrointestinal Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pancreatic cysts Chronic pancreatitis		3 years 10 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic alcoholism				
19A. DATE OF OPERATION 3 7/6 + 7/8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GI Hemorrhage		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 25, 1972 to July 9, 1972 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 9, 1972 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE Leslie Pearlstein MD				23B. DATE SIGNED 7/11/72
23C. PHYSICIAN'S NAME (Type) LESLIE PEARLSTEIN MD		23D. ADDRESS Baltimore, Md 21218 3900 Loch Raven Boulevard		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972		
25B. NAME OF REGISTRAR L. H. H. H.		25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun Street		



FUNERAL DIRECTOR: IMPORTANT

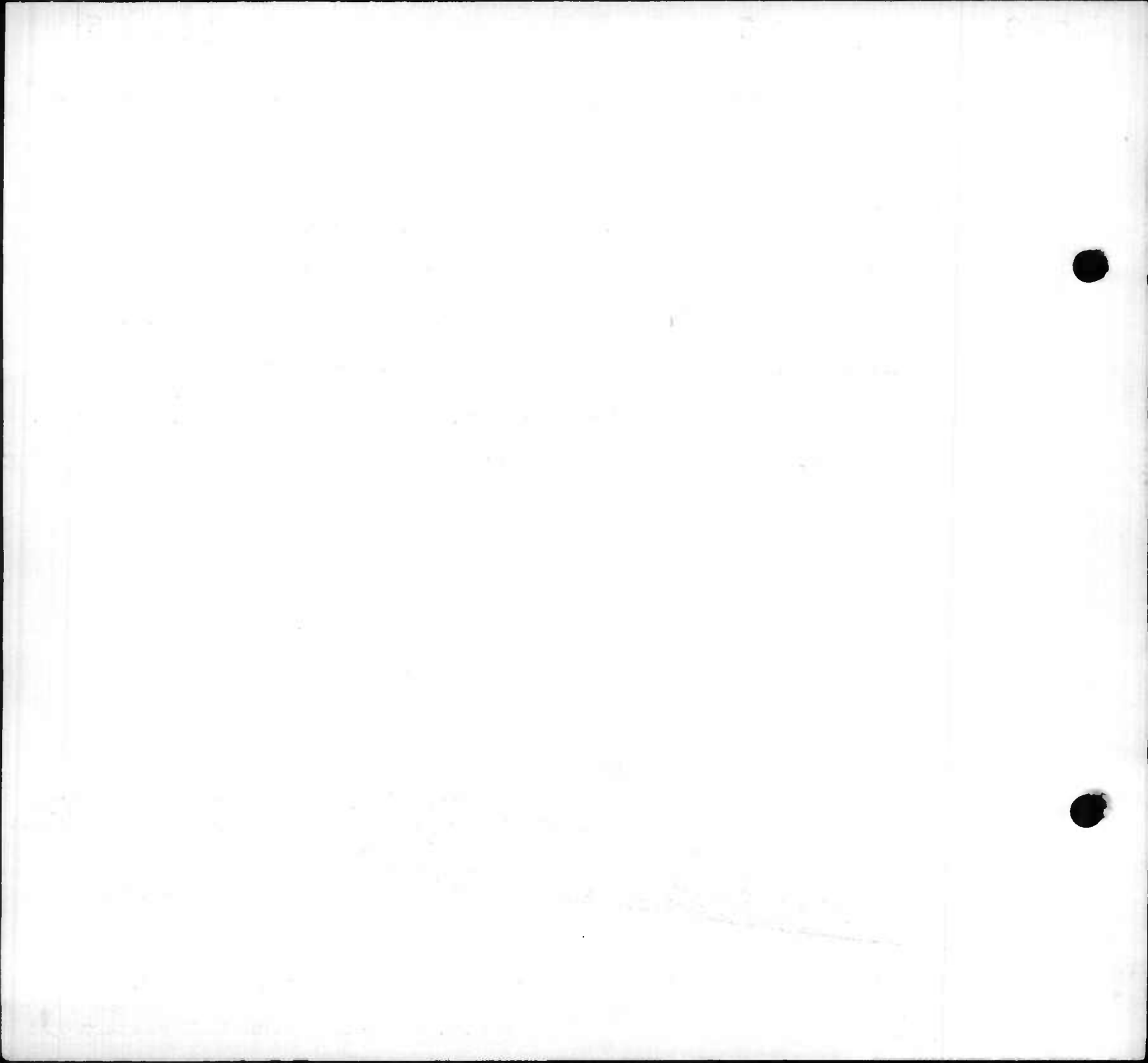
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 06464</u>	
J-525 72 06464		CERTIFICATE OF DEATH			
BIRTH NO. <u>STATE OF MARYLAND-DEME</u>		1. NAME OF DECEASED (Type or Print) <u>John</u>			
2. DATE AND HOUR OF DEATH <u>July 11, 1972</u> <u>3:05 p.m.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Provident Hospital, Inc.</u> <u>2600 Liberty Height Ave.</u> <u>Baltimore, Md. 21215</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1501</u>		5. SEX <u>Female</u> 6. RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>8-31-20</u>		9. AGE (In years last birthday) <u>51</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Henry Baskerville</u>		14. MOTHER'S MAIDEN NAME <u>Edna</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-14-7430</u>		17. INFORMANT <u>Clinton Johnson (Husband)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEPATIC FAILURE</u>		19. DATE OF OPERATION <u>17-3-72</u>			
20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>HEPATIC FAILURE</u> (B) MARKED LIVER CIRRHOSIS (C) _____		21. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>OBSTRUCTIVE JAUNDICE</u>			
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>		23. DATE OF OPERATION <u>17-3-72</u>			
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <input type="checkbox"/>		26. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) <input type="checkbox"/>	
27. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		29. HOW DID INJURY OCCUR <input type="checkbox"/>	
30. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1972</u> to <u>July 11, 1972</u> that (I) (we) last saw the deceased alive on <u>July 11, 1972</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
31. SIGNATURE <u>M. Cabling</u>		32. DATE SIGNED <u>7-11-72</u>		33. PHYSICIAN'S NAME (Type) <u>M. Cabling M.D.</u>	
34. ADDRESS <u>Provident Hospital 2600 Liberty Height Ave.</u>		35. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1972</u>			
36. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Pk.</u>		37. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>			
38. FUNERAL DIRECTOR <u>Kelson, F.H.</u>		39. ADDRESS <u>1348 Calhoun Street</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 06465		BALTIMORE CITY HEALTH DEPARTMENT		72 06465	
BIRTH NO. STATE OF MARYLAND-DEATH		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Joseph Pniewski</u>		2. DATE AND HOUR OF DEATH <u>7/10/72</u> <u>12 30</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>105</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Nursing & Convalescent Center</u> <u>1213 Light St. Baltimore, Md.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>235 S. Chester St.</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/15/91</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coat presser</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Taylor shop</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Bronislaw Pniewski</u>		14. MOTHER'S MAIDEN NAME <u>Jozefa Nasarzewska</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-2216-A</u>		17. INFORMANT <u>Mrs. Sophie Pniewski</u> ADDRESS <u>235 S. Chester St.</u>	
18. <u>412.414.250.9</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Terminal bilateral pneumonia</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A.S.C.V. Disease</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes Mellitus</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>		(C) <u>?</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/18/72</u> to <u>7/10/72</u> that (I) (we) last saw the deceased alive on <u>7/10/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph S. Blum MD</u>		23B. DATE SIGNED <u>7/11/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM MD</u>		23D. ADDRESS <u>11154 CALVERT ST</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/13/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Rosary Cemetary</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1972</u>		25B. NAME OF REGISTRAR <u>Indy...</u>		25C. FUNERAL DIRECTOR <u>M.F. Sadowski & Sons</u> ADDRESS <u>1808 Eastern Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-4001		Baltimore City Health Department		72 06466	
BIRTH NO. 72 06466		CERTIFICATE OF DEATH		REG. NO. 72 06466	
1. NAME OF DECEASED (Type or Print) HALL, CHARLES S.		2. DATE AND HOUR OF DEATH 7/7/72 0.20AM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD THE UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2714 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4301 DEWEY AVENUE			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-8-94	9. AGE (In years last birth) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10B. KIND OF BUSINESS OR INDUSTRY APT. BUILDING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME RICHARD HALL		14. MOTHER'S MAIDEN NAME MARTHA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service YES WORLD WAR I		16. SOCIAL SECURITY NO. 215-05-4431		17. INFORMANT MRS. EVA DAVIS 4301 DEWEY AVE.	
18. 569.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Hypovolemic Shock DUE TO, OR AS A CONSEQUENCE OF: (B) 6. I. bleeding DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work <input type="checkbox"/> Not White At <input type="checkbox"/> Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/6/72 19 72 to 7/7 19 72 that (I) (we) last saw the deceased alive on 7/7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Luis Sirotzky</i>		23B. DATE SIGNED 7/7/72		23C. PHYSICIAN'S NAME (Type) Luis Sirotzky	
23D. ADDRESS Union Memorial Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 7-11-1972		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL CEM.		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972		25B. NAME OF REGISTRAR <i>Edney Johnson</i>		25C. FUNERAL DIRECTOR NUBBER FUNERAL HOME 3035 W. NORTH AVE.	

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The Union Memorial Hospital

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72 06407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06407

BIRTH NO.

STATE OF MARYLAND - DMC

REG. NO.

1. NAME OF DECEASED (Type or Print) William M. Cole Jr.				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION University Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 7 9 1972 9:45p			
6. SEX male				7. RACE negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-29-1939				10. AGE (In years lost birthday) 32		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William M. Cole Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Alice Harding				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 218-34-2116				18. INFORMANT ADDRESS Mrs. Alice Cole Woodstock, Maryland			
19. E966X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Stabwound of chest and heart				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 7-9-72				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED jail			
21. AUTOPSY? (Yes or No) yes				22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) jail				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) House of Correction, Jessup, Md.			
22D. TIME OF INJURY (APPROX.) Month Day Year 7-9-72 8:30 p m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> Stabbed during altercation.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-10-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-1972		24C. NAME of CEMETERY or CREMATORY St. Alphonsas Cemetery Woodstock Maryland		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1972		25B. NAME OF REGISTRAR Sidney H. Hooton		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE			

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72 06468

BALTIMORE CITY HEALTH DEPARTMENT

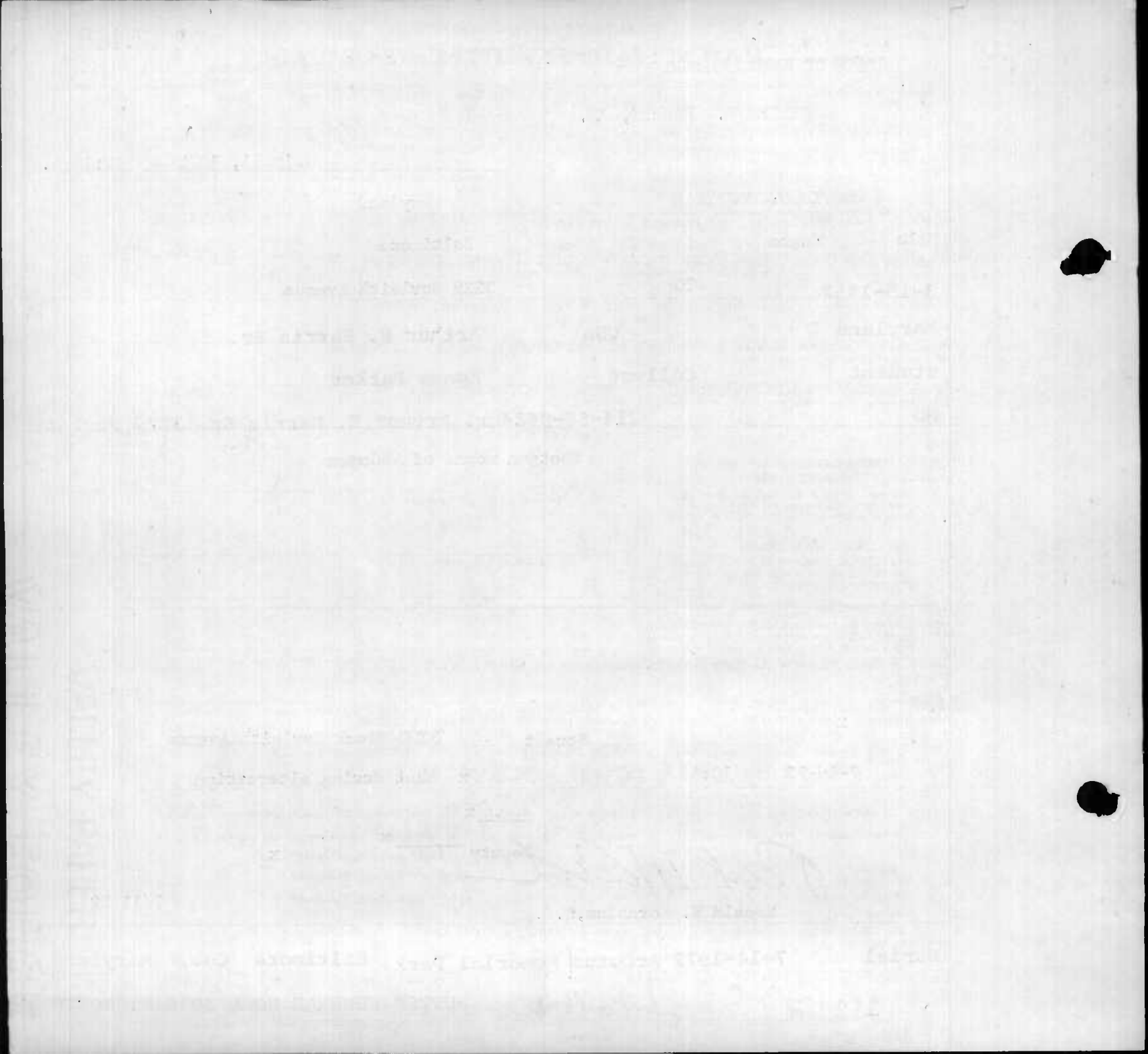
72 06468

STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ARTHUR E. HARRIS, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour July 11, 1972 12:10 A.M.	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 3-15-1952		10. AGE (In years lost birthday) 20	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	E. STREET AND NUMBER 3229 Burleith Avenue
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		14B. KIND OF BUSINESS OR INDUSTRY College	13. FATHER'S NAME Arthur E. Harris Sr.
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-58-8624	15. MOTHER'S MAIDEN NAME Agnes Parker
19. E 965X		18. INFORMANT ADDRESS Mr. Arthur E. Harris Sr. 3229 Burleith	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Shotgun wound of Abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME OF INJURY (APPROX.) 7-10-72 10:48 P.M.		22C. WHERE DID INJURY OCCUR? 3200 Block Burleith Avenue	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 7/11/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-1972	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. 11/12/1972		25B. NAME OF REGISTRAR Sidney H. Weston	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVENUE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06469	
BIRTH NO. 72 06469		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PETERSON, JOSEPH A.		2. DATE AND HOUR OF DEATH 7-11-72 7:15/A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1503			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSP. E.R. 38		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1625 Warwick Avenue					
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-19-1892	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Trucking Company		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Eugene Peterson		14. MOTHER'S MAIDEN NAME Julia Sweet			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 080-10-0732		17. INFORMANT Mrs. Alberta Davis	
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PROBABLE ACUTE MI		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE CARDIOVASCULAR DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: SEVERAL YRS. (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH less than 5 minutes	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PROBABLE ACUTE PANCREATITIS					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-10 19 72 to 7-11 19 72 , that (I) (we) last saw the deceased alive on 7-11 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William E. Randall, Jr. M.D. OEGREE				23B. DATE SIGNED JULY 11, 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-1972		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1972		25B. NAME OF REGISTRAR Shirley H. ...		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE	

Internal Security - 1-11-55

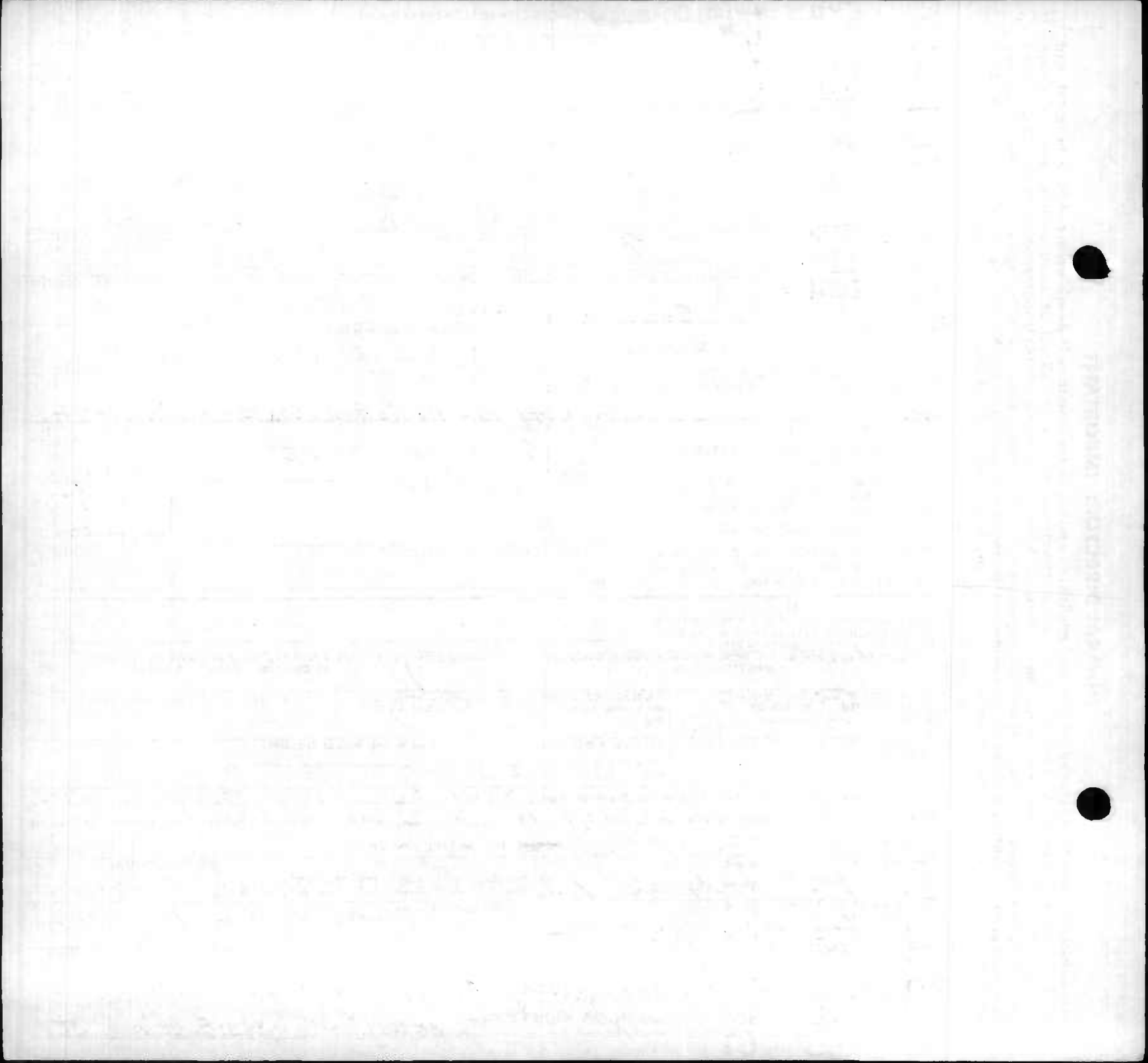
University of California

MAILED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

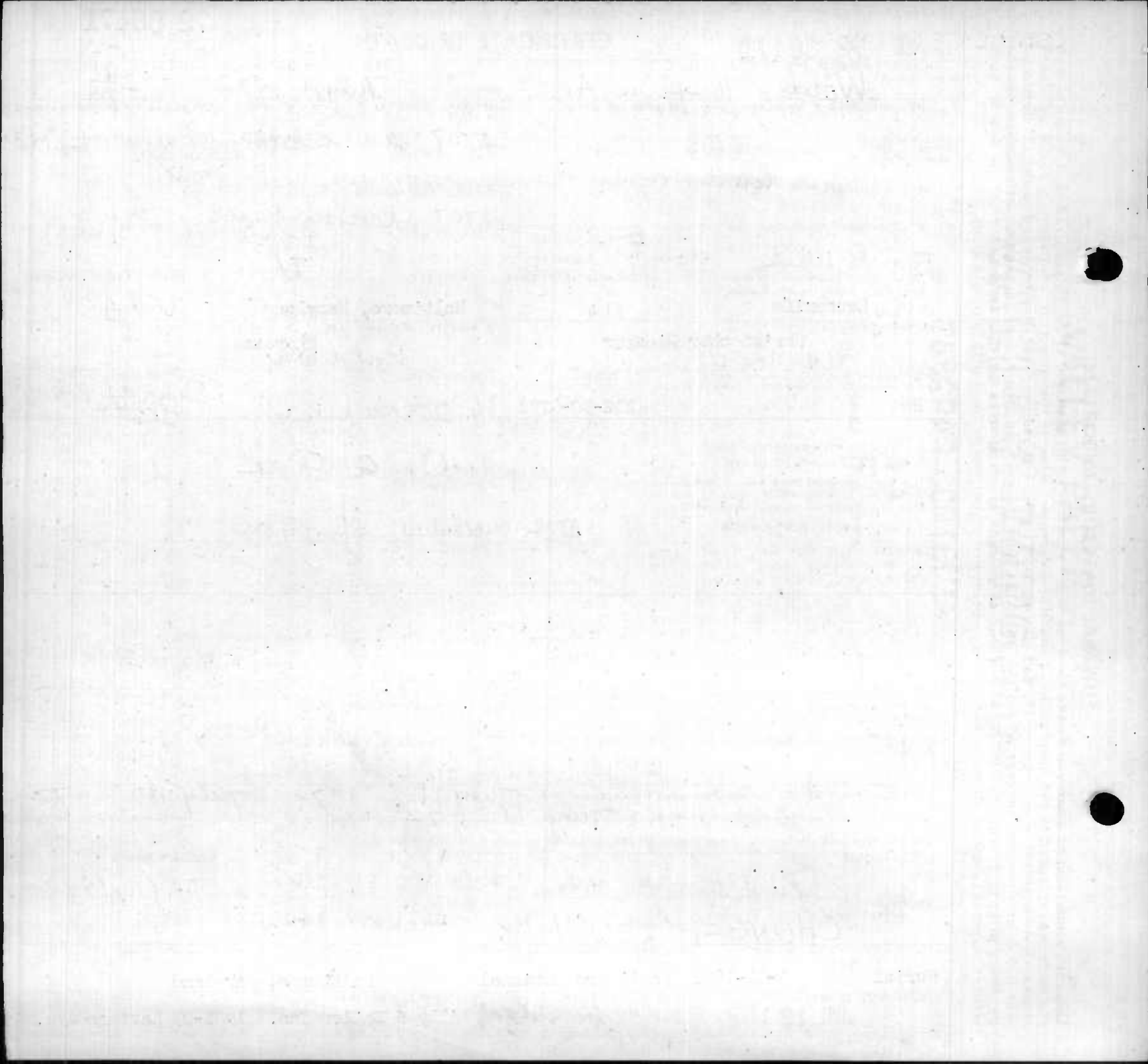
STATE OF MARYLAND - DEMO BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 06470		
BIRTH NO. 72 06470								
1. NAME OF DECEASED (Type or Print) MAJOR ANDERSON				2. DATE AND HOUR OF DEATH 7/11/72 6:20 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital 33				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER 1510 N. LINWOOD AVE.				
5. SEX M	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/10	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done; if not, give occupation, if retired) STEEL MILL			10B. KIND OF BUSINESS OR INDUSTRY Steel Mill		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAM ANDERSON				14. MOTHER'S MAIDEN NAME BESSIE MOOREN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-6948		17. INFORMANT MRS. PHYLLIS ANDERSON 1510 N. LINWOOD AVE.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH MASSIVE HEMOPTYSIS (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CA of lung (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH CA diagnosed Oct, 1971.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from JULY 10 1972 to JULY 11 1972 that (I) (we) last saw the deceased alive on JULY 11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
23A. SIGNATURE NEILL S. HIRST MD.				23B. DATE SIGNED JULY 11, 1972		23C. PHYSICIAN'S NAME (Type) NEILL S. HIRST MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-72		24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEMORIAL PARK ARBUTUS, Md.		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1972		25B. NAME OF REGISTRAR Frederick W. Horton		25C. FUNERAL DIRECTOR Randolph J. Collick		25D. ADDRESS 2431 E. Oliver St.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPT. BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 06471	
BIRTH NO. 72 06471				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Woods, Josephine A.		2. DATE AND HOUR OF DEATH July 11, 1972 2:21 pm M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD The Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4707 Shamrock Avenue, 2642			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1	9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no Housewife
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Christopher Riesner unknown		14. MOTHER'S MAIDEN NAME Theresa unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-30-8792		17. INFORMANT Mr. Catherine Kres Same as patient	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiogenic Shock Acute myocardial infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NO		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NO	
22. I certify that (I) (this hospital) attended the deceased from July 11, 1972 to July 11, 1972 , that (I) (we) last saw the deceased alive on July 11, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chung-Hsien Yu M.D.		23B. DATE SIGNED July 11, 1972			23C. PHYSICIAN'S NAME (Type) CHUNG-HSIEN YU M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-1972		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1972			
25B. NAME OF REGISTRAR Andrew W. Horton		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.			



1
M-220

72 06472

STATE OF MARYLAND-DEPT
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 06472

1. NAME OF DECEASED (Type or Print) JOHN MAASIK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 Room 254 101 E. Mount Royal Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 9 1972 6:10p M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Aug. 29, 1901		10. AGE (In years last birthday) 70 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Estonia		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seaman		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Red Diekey		ADDRESS 1216 E. Baltimore St.	
19. 4/12-4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-10-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-12-1972	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1972		25B. NAME OF REGISTRAR Sidney H. Houston	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901-07 Eastern Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND—DHMH BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 6473	
BIRTH NO. 72 06473		1. NAME OF DECEASED (Type or Print) RINGS DORF, CHARLES E.		2. DATE AND HOUR OF DEATH 7/11/72 4:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2739			
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03/14/49	
9. AGE (in years last birthday) 73		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DENTAL TECHNICIAN		11. BIRTHPLACE (State or foreign country) DE LAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PETER RINGS DORF				14. MOTHER'S MAIDEN NAME LEVENIA SNYDER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I		16. SOCIAL SECURITY NO. 214-20-7537		17. INFORMANT ADDRESS MRS. W. CLIFFORD NORRIS (SAME)			
18. 4101 I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF:					
		(C) Probably M.I.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/11/72 to 7/11/72, that (I) (we) last saw the deceased alive on 7/11/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Luis Sirotzky				23B. DATE SIGNED 7/11/72			
23C. PHYSICIAN'S NAME (Type) Luis Sirotzky				23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-72		24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens		24D. LOCATION (City, town, or county) (State) Bel Air, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1972		25B. NAME OF REGISTRAR Sidney Whorton		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	

72 06474

STATE OF MARYLAND-DHMH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06474

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Shuman A. MOBLEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2914 Wyman Parkway 7-17-72		3. DATE PRONOUNCED DEAD Month Day Year Hour July 11, 1972 11:48 A.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1207			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12-11-1899		10. AGE (In years lost birthday) 72	
11. BIRTHPLACE (State or foreign country) Beech Creek, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Construction Armstrong Cork Co.		15. MOTHER'S MAIDEN NAME Sarah Hall	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-09-0501A	
18. INFORMANT Mr. A. Bainbridge Mobley Bethesda, Md.		ADDRESS 20014	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Epilepsy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. DATE SIGNED 7/11/72 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-72	
24C. NAME OF CEMETERY or CREMATORY Greenmount		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1972		25B. NAME OF REGISTRAR Sidney B. Heston	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 14905 York Rd. Balto., Md. 21212	

7-17-1972 - Correction form from Funeral Director - Henry W. Jenkins & Sons Co.
4905 York Road, Balto., Md. 21212
J. Slade, Pres.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH				BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		72 06475		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		John M. Phelps		2. DATE AND HOUR OF DEATH 7-11-72 2:20 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		A. STATE Maryland B. COUNTY Howard C. CITY OR TOWN Columbia D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 10370 Felkner Ridge Circle			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-20	9. AGE (In years last birthday) 52	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier		10B. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Raymond Phelps		14. MOTHER'S MAIDEN NAME Gertrude (Unknown)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service WW II -		16. SOCIAL SECURITY NO. 322-28-2480		17. INFORMANT Marion Phelps ADDRESS 10370 Felkner Ridge Cr. Columbia, Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Carcinoma of stomach DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Congestive Heart Failure					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 6-24 19 72 to 7-11 19 72 that (B) (we) last saw the deceased alive on 7-11-72 19 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (not) view the body after death.					
23A. SIGNATURE Thomas V. Whitten M.D.		23B. DATE SIGNED 7-12-72		23C. PHYSICIAN'S NAME (Type) Thomas V. Whitten, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-72		24C. NAME OF CEMETERY OR CREMATORY Gettysburg National	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1972		25B. NAME OF REGISTRAR Andrew Indurston		25C. FUNERAL DIRECTOR Witoldes Howard County	
25D. ADDRESS Columbia Pike Ellicott City, Md.					

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE CENSUS

U.S. Census Bureau
Washington, D.C.

1/12/21
The Census
U.S. Census Bureau
Washington, D.C.
(1/12/21)
1/12/21

1/12/21
U.S. Census Bureau
Washington, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DHMH BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 06476

BIRTH NO. 72 06476

1. NAME OF DECEASED
(Type or Print)

Czeslaw Struzinski

2. DATE AND HOUR OF DEATH

7-11-72

10:15

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

102

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

120 S. East Avenue

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

11-16-93

9. AGE (In years last birthday)

78

11 Under 1 Yr.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY

retired

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unk

14. MOTHER'S MAIDEN NAME

unk

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

215-05-3342

17. INFORMANT

ADDRESS

Mr. Richard Dubicki, 120 S. East Avenue, 21224

18. 162.1 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-11-72 to 7-11-72 that (I) (we) last saw the deceased alive on 7-11-72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/14/72

24C. NAME OF CEMETERY OR CREMATORY

St. Stanislaus Cem.

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 12 1972

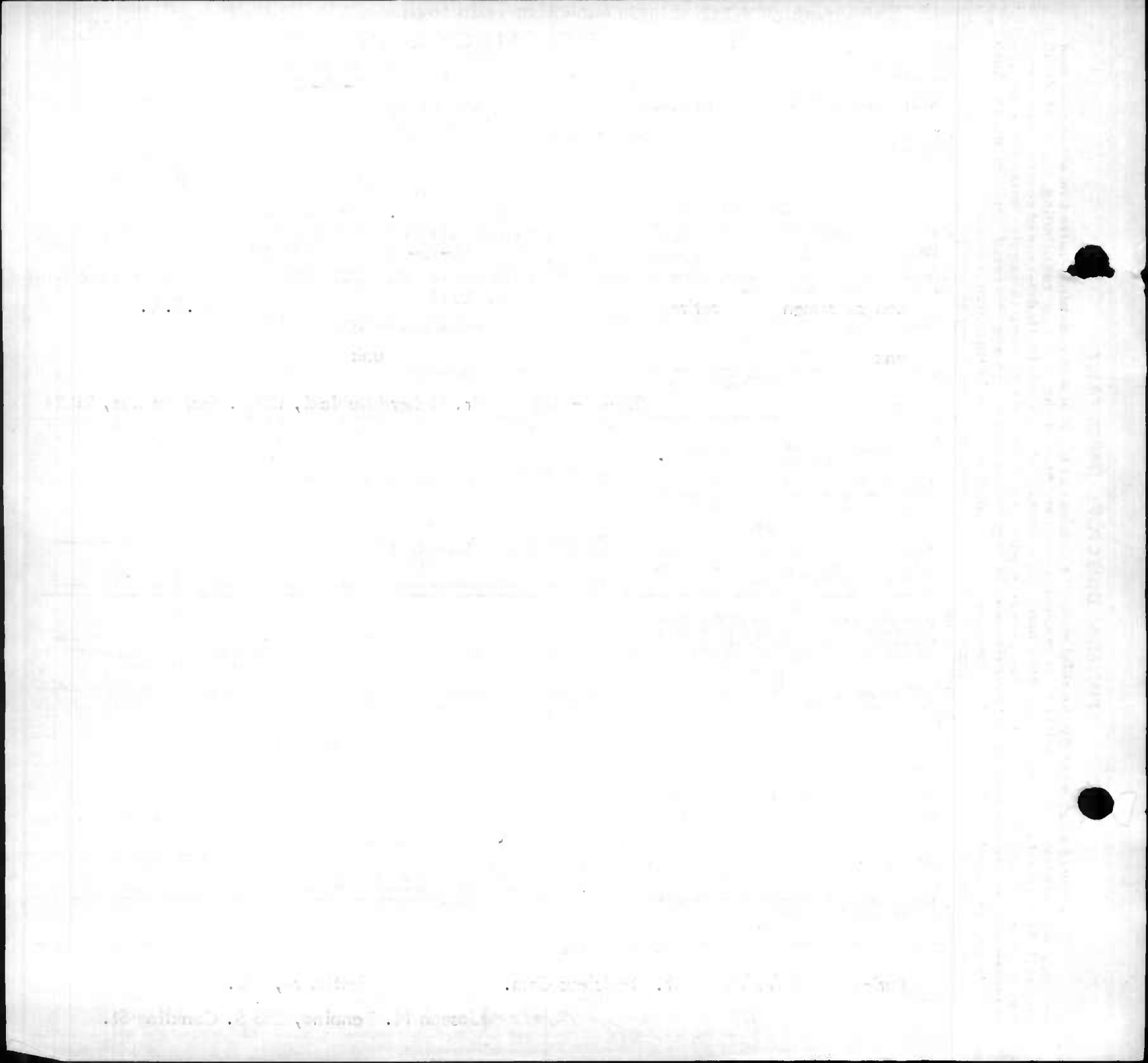
25B. NAME OF REGISTRAR

Sidney W. Weston

25C. FUNERAL DIRECTOR

Joseph N. Zannino, 263 S. Conkling St.

ADDRESS



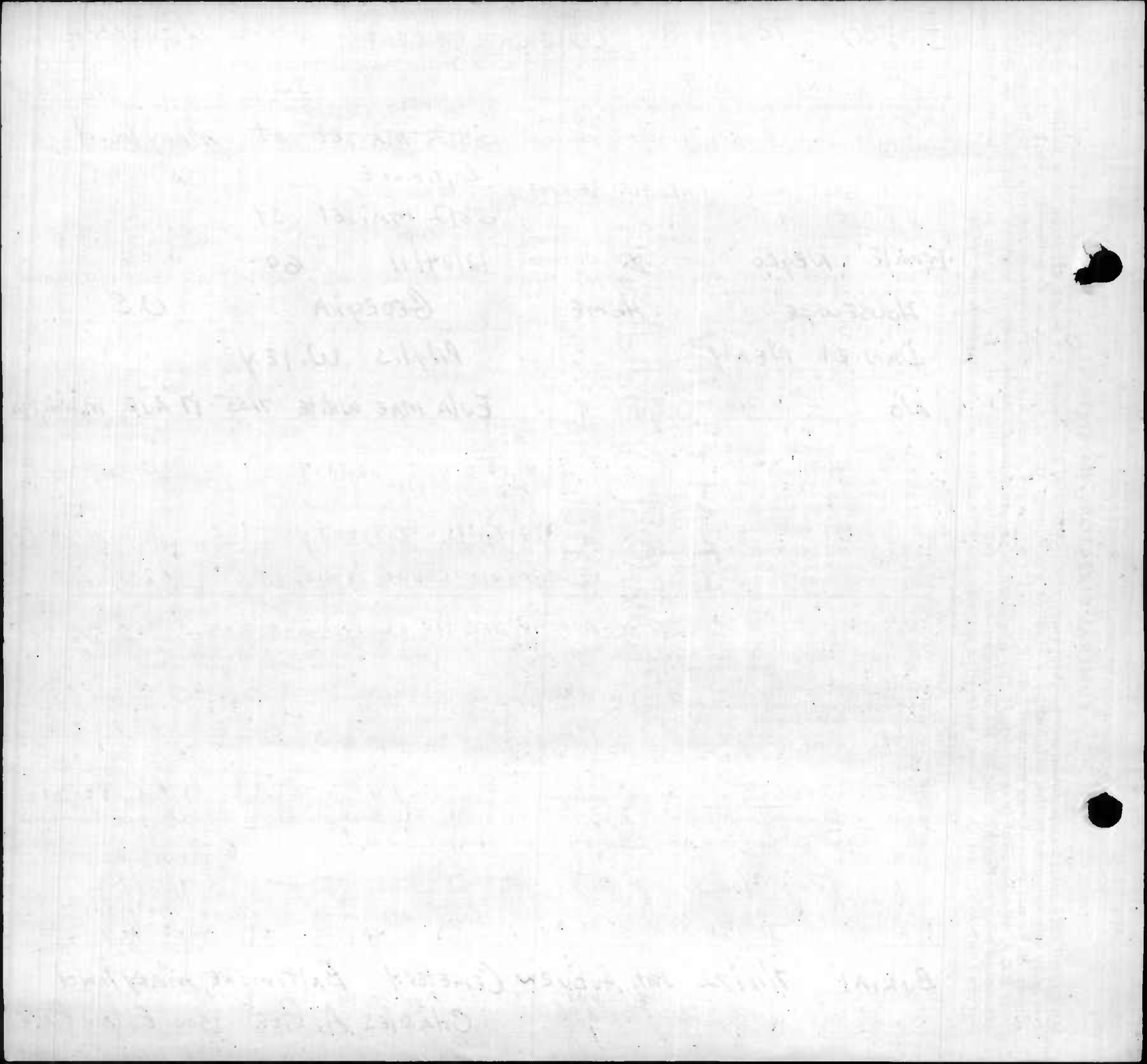
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-320 72 06478		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06478	
BIRTH NO. 72 06478		STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) IRENE EDGE			2. DATE AND HOUR OF DEATH JULY 5 7:25 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 2812 MAISEL ST. MARYLAND C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2812 MAISEL ST. 2533		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/11	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) GEORGIA	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME DANIEL NEALY		
14. MOTHER'S MAIDEN NAME PHYLIS WILEY			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT EULA MAE WHITE 7455 17th AVE. MIAMI, FL.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 10+ YEARS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNCERTAIN SEVERAL DAYS 2-3 YEARS		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 4 1972 to JULY 5 1972, that (I) (we) last saw the deceased alive on JULY 5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert J. Bauer, M.D.				23B. DATE SIGNED 7/5/72	
23C. PHYSICIAN'S NAME (Type) ROBERT J. BAUER, M.D.				23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL 3001 S. HANOVER ST. BALT., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/11/72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUL 12 1972		24F. NAME OF REGISTRAR Dudley W. Horton	
24G. FUNERAL DIRECTOR CHARLES A. RICE		24H. ADDRESS 1300 Eutaw Place			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

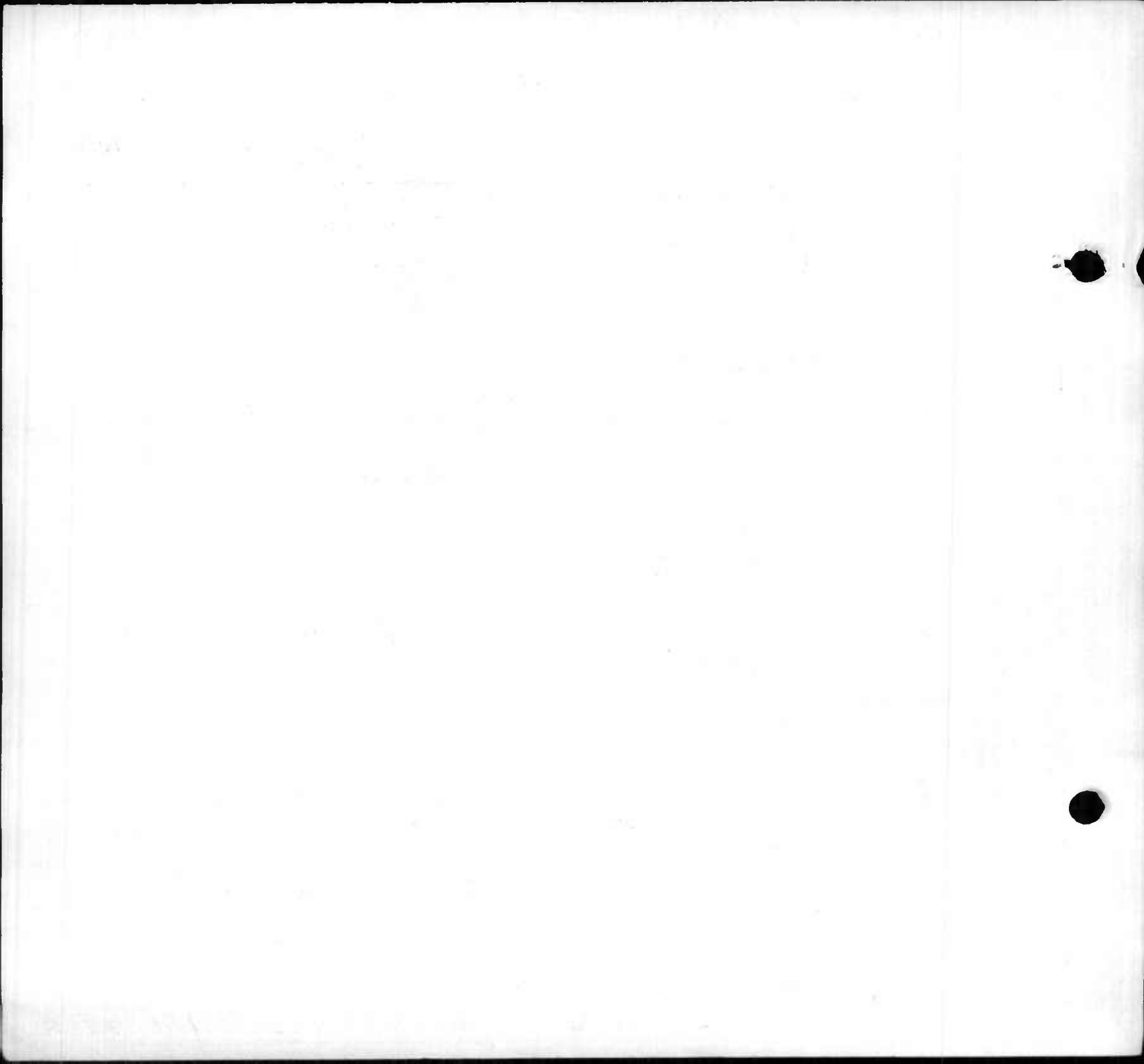
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>72 06479</u>	
BIRTH NO. <u>V-520</u> <u>72 06479</u>		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <u>YOUNG, MR. JOHN EDWARD</u>		2. DATE AND HOUR OF DEATH <u>7/10/72</u> <u>3:15 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u> <u>Fayette and Pulaski St. Balt. Md.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALT. CITY</u> <u>2001</u>	
		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1822 W. Lexington St.</u>	
5. SEX <u>Male</u>	6. RACE <u>BLACK</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/5/05</u>
		9. AGE (In years last birthday) <u>67</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>? Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>WIK</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Thomas</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <u>Pearl Dublin</u> ADDRESS <u>1822 W Lexington</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A), stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pulmonary embolus, rt.</u> <u>hours</u> DUE TO, OR AS A CONSEQUENCE OF <u>main pulmonary artery</u> (B) <u>Multiple recent superficial gastric ulcers with GI. Bleeding</u> <u>days</u> DUE TO, OR AS A CONSEQUENCE OF <u>Acute hemorrhagic pancreatitis</u> <u>days</u> (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>July 10, 1972</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Retrieval of Foley Catheter</u>	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>July 2, 1972</u> to <u>July 10, 1972</u> that (1) (we) last saw the deceased alive on <u>July 10, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>H. S. Lee, M.D.</u>		23B. DATE SIGNED <u>July 11, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>HOA SUNG LEE M.D.</u>		23D. ADDRESS <u>BON SECOURS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/14/72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1972</u>	25B. NAME OF REGISTRAR <u>Andrew Whitton</u>	25C. FUNERAL DIRECTOR <u>Charles A Rice</u> ADDRESS <u>1300 Entaw Pl.</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-560 72 06480		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06480	
CERTIFICATE OF DEATH					
BIRTH NO. STATE OF MARYLAND-DEMH		1. NAME OF DECEASED (Type or Print) <i>Anna Mae Connor</i>			
2. DATE AND HOUR OF DEATH		7-5-72 10:25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
38 University of Maryland		Md. Baltimore 2047			
5. SEX F		6. RACE N N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. DATE OF BIRTH		10. AGE (in years last birthday)	
housewife		11/17/15		57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		—		N.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY	
Plummer Fields		—		USA	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		242-05-3453		Mr. William Connor 37 N. Culver St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		1 day	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:		—	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Multiple myeloma.		1 yr.	
DUE TO, OR AS A CONSEQUENCE OF:		(C) —		—	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		nephrotic syndrome		1 mms.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF (INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. (INJURY OCCURRED) While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 26 19 72 to July 5 19 72 that (I) (we) last saw the deceased alive on July 5 19 72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
P. B. Baurzo		7-5-72		—	
23D. ADDRESS		23E. FUNERAL DIRECTOR		23F. ADDRESS	
5 Panhurst Court Towson Md.		Joseph E. Russ		2222 W. North Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-8-72		Arbutus Mem. Park	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		24F. LOCATION (City, town, or county)	
Arbutus		Md.		Arbutus	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 12 1972		L. D. Whitton		Joseph E. Russ	



72 06481

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 06481

BIRTH NO. L-000 STATE OF MARYLAND-DEME

REG. NO.

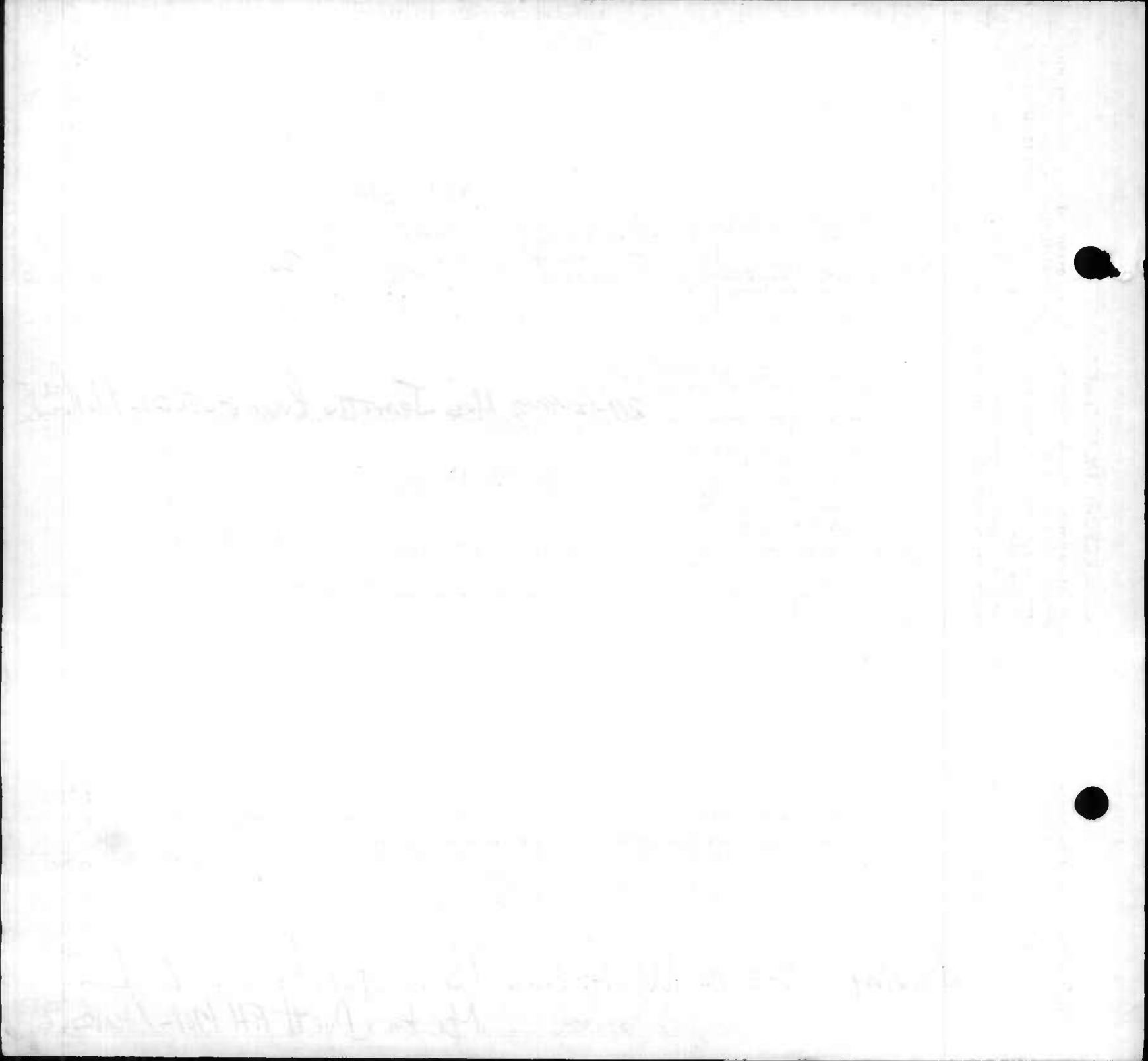
1. NAME OF DECEASED (Type or Print) GEORGE D. LEE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 5423 Crismer Ave. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 23, 1972 7:00 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Jan. 17, 1899		10. AGE (In years last birthday) 73	
11. BIRTHPLACE (State or foreign country) Matthews, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Morris Lee		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2831	
15. MOTHER'S MAIDEN NAME Laura Hall		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr. Ossie Williams 237 Robert St.	
19. 419.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-24-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jul 1, 1972	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem Pk.		24D. LOCATION (City, town, or county) (State) Arbutus Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1972		25B. NAME OF REGISTRAR Sidney Johnson	
25C. FUNERAL DIRECTOR Joseph L. Run		ADDRESS 22224 North Ave	

WALLEY & CO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 06482</u>	
L-235 72 06482		CERTIFICATE OF DEATH	
BIRTH NO. <u>STATE OF MARYLAND-DEMD</u>		2. DATE AND HOUR OF DEATH <u>8-8-72</u> <u>7:30</u> A.M.	
1. NAME OF DECEASED (Type or Print) <u>Leighton, James Alphonso</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD. (No County)</u> B. COUNTY <u>1403</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital Incorporated</u> <u>2600 Liberty Hgts, Balto, Md.</u>		E. STREET AND NUMBER <u>2117 Division St.</u>	
5. SEX <u>M</u>	6. RACE <u>Human</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-09</u> 9. AGE (in years last birthday) <u>62</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Leighton</u>		14. MOTHER'S MAIDEN NAME <u>Dinah</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-9012</u>	
17. INFORMANT <u>Mrs Jewette Bruce</u>		ADDRESS <u>3621 Mohawk Ave</u>	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Acute Myocardial infarction; CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>HEVD</u>	
19A. DATE OF OPERATION <u>7-13-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>John G. Yool, M.D.</u>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-13-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1972</u>		25B. NAME OF REGISTRAR <u>Robert Dye</u>	
25C. FUNERAL DIRECTOR <u>Robert Dye</u>		25D. ADDRESS <u>1701-1701-1701-1701</u>	



C-160		72 06483		BALTIMORE CITY HEALTH DEPARTMENT		72 06483	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.		STATE OF MARYLAND-DEME					
1. NAME OF DECEASED (Type or Print) WILLIAM COOPER				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 200 2908 Westwood Avenue				3. DATE PRONOUNCED DEAD Month Day Year Hour July 9, 1972 2:35 A. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1506							
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH June 5, 1892		10. AGE (In years lost birthday) 80		E. STREET AND NUMBER 2908 Westwood Avenue			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME WILLIAM COOPER			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME LOUISE COOPER			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 214-01-3862		18. INFORMANT ADDRESS MRS. GERTRUDE COOPER 2908 WESTWOOD AVE.			
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/9/72							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-12-72		24C. NAME of CEMETERY or CREMATORY MT. AUBURN CEMETERY		24D. LOCATION (City, town, or county) (State) BSLTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1972		25B. NAME OF REGISTRAR Aidey		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT FUNERAL HOME, 1701 LAURENS ST.			



WILLIAM COOPER
LUCAS COOPER
ST-11-3001 ARE, NORTH SIDE DOOR, 1000 WEST 1000
1000

WILLIAM COOPER

WILLIAM COOPER
ST-11-3001 ARE, NORTH SIDE DOOR, 1000 WEST 1000
1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
D-600		72 06484		72 06484	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Derr, Louis W.		7-8-72		6 09 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		A. STATE Maryland		B. COUNTY 2641	
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5622 Gerland Avenue-21206			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1931	9. AGE (In years last birthday) 40	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucking Foreman
		10B. KIND OF BUSINESS OR INDUSTRY Eastern Products Co.	11. BIRTHPLACE (State or foreign country) Balto, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence W. Derr		14. MOTHER'S MAIDEN NAME Eleanor B. Watkins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-26-5913		17. INFORMANT Mrs. Doris A. Derr- 5622 Gerland Ave.-21206	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Acute Myocardial Infarction		12 hrs.	
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 7, 1972 to July 8, 1972, that (I) (we) last saw the deceased alive on July 7, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard J. Cohen M.D.		23B. DATE SIGNED 7-8-72			
23C. PHYSICIAN'S NAME (Type) Dr. BERNARD J. COHEN		23D. ADDRESS The Marylander Apts 3501 St. Paul St. #212B			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1972		25B. NAME OF REGISTRAR A. Miller	
25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.		25D. ADDRESS			

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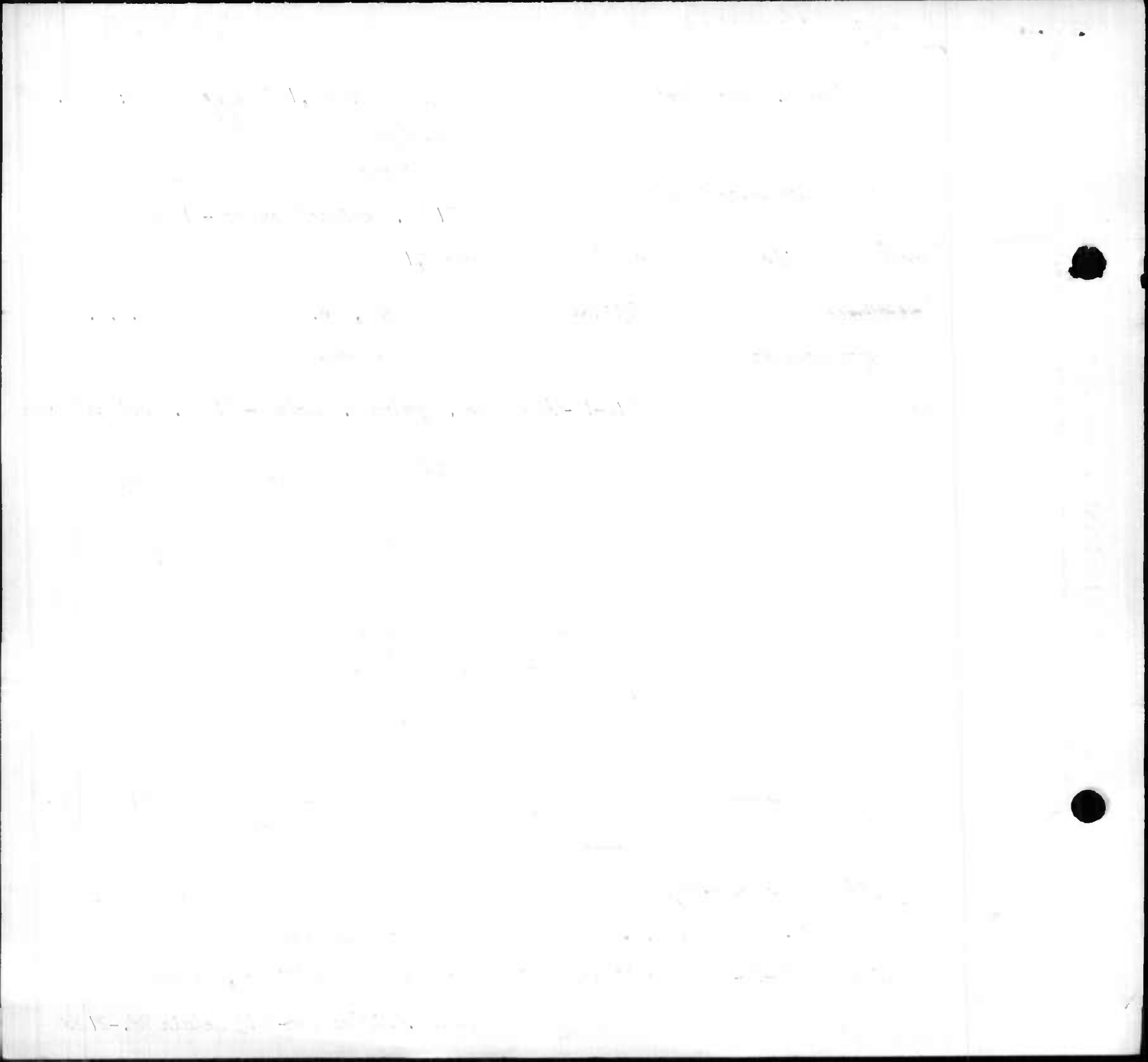
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

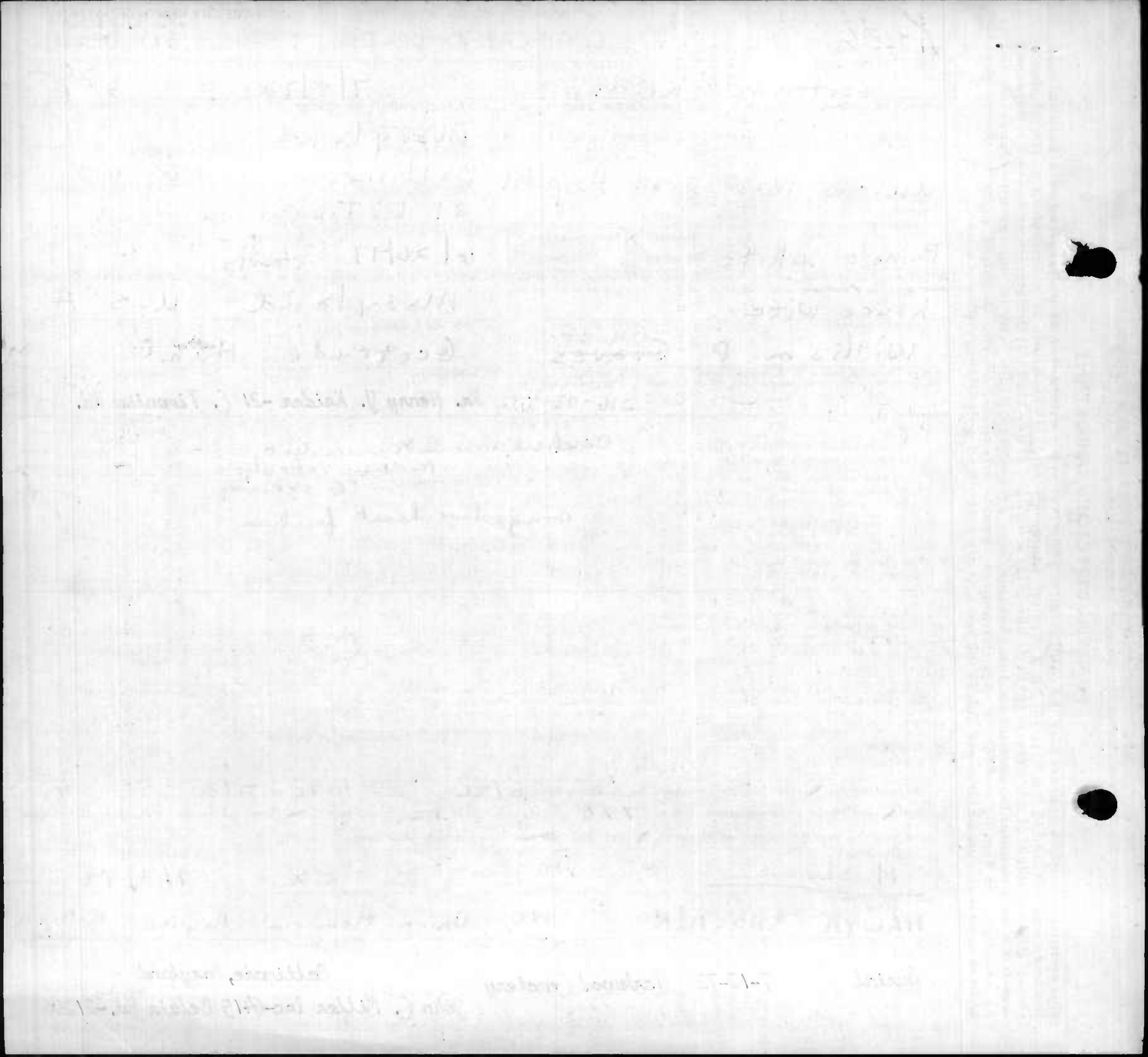
L-243		72 06485		BALTIMORE CITY HEALTH DEPARTMENT		72 06485	
BIRTH NO. STATE OF MARYLAND-DEMD				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Cona A. Lescolle				2. DATE AND HOUR OF DEATH July 8, 1972 5:30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalescent Home				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 103			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 715 S. Montford Avenue -21224			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1902		9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) York, Pa.		12. CITIZEN OF WHAT COUNTRY? U.D.A.	
13. FATHER'S NAME Harry Kessler				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-16-4449		17. INFORMANT Mrs. Evelyn D. Barlow - 715 S. Montford Avenue			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
				(B) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: yes			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Brain Syndrome						yes	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/8/1972 to 7/8/1972 that (I) (we) last saw the deceased alive on 7/7/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 7/10/72		23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.	
				23D. ADDRESS 4900 Belair Road 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-12-72		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1972		25B. NAME OF REGISTRAR John C. Miller Inc		25C. FUNERAL DIRECTOR John C. Miller Inc		ADDRESS 6415 Belair Rd. -21206	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

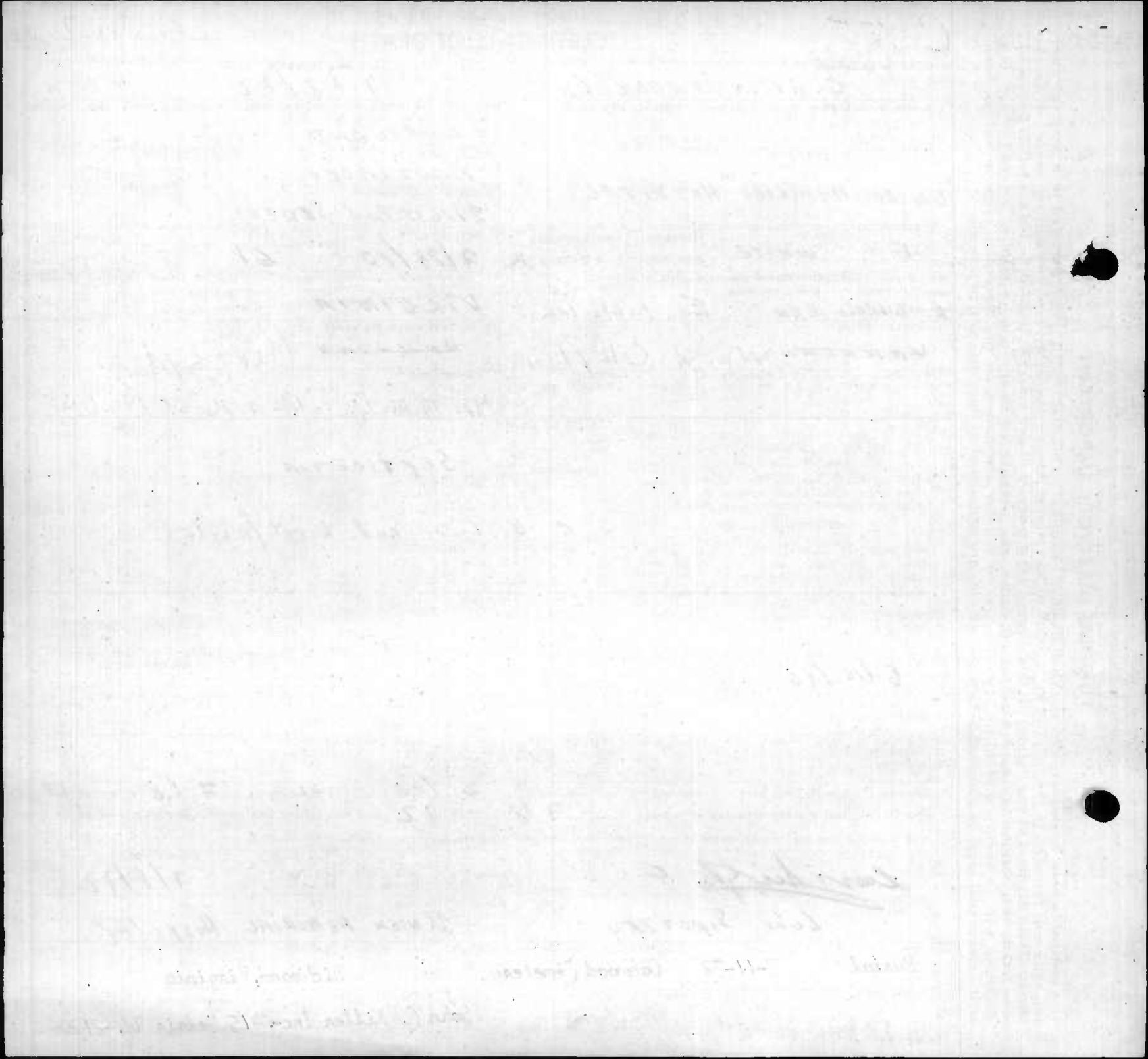
72 06486		BALTIMORE CITY HEALTH DEPARTMENT		72 06486	
K-636 STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH		REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Gertrude M. Krider		7/8/72. 2:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland BALTO 5300			
Union Memorial Hospital		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
44		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		21 E. Timonium Road			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/26/17	76 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
house wife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William P. Graef		Gertrude Hunt		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		216-03-4152		Mr. Henry J. Krider - 21 E. Timonium Rd.	
18. 4 27.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Cerebral vascular accident			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		kidney infection			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		congestive heart failure			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (N) (this hospital) attended the deceased from 6/26 1972 to 7/8 1972, that (N) (we) last saw the deceased alive on 7/8 1972 and that in (N) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
M. Shocair				7/8/72.	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MAWYA SHOCAIR		M.D. Union Memorial Hospital Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7-12-72		Parkwood Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 12 1972		Dorothy H. Heston		John C. Miller Inc - 6415 Belair Rd. - 21206	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

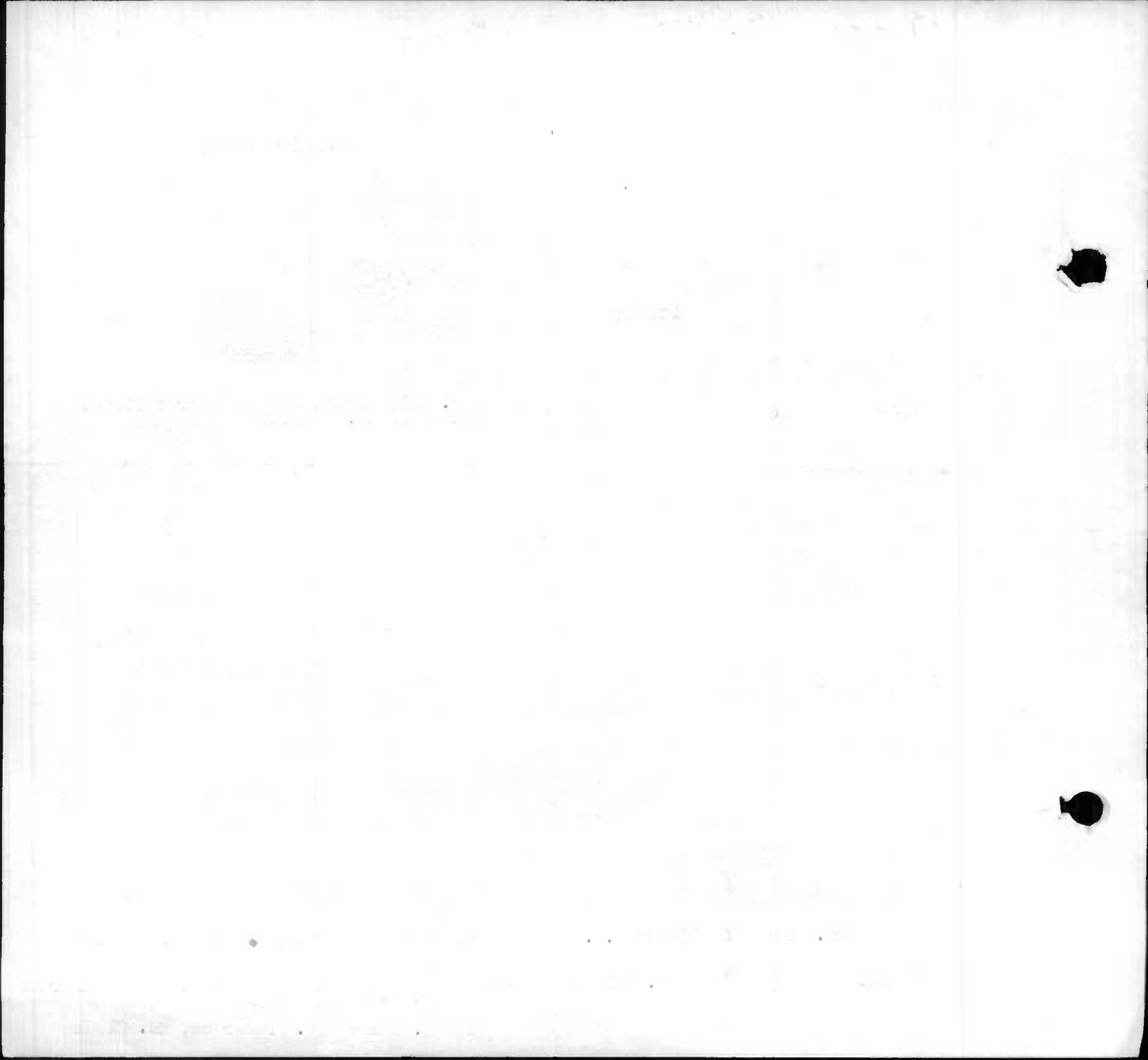
72 06487		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06487	
C-435		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>CLAYTON, FRANK D.</u>		2. DATE AND HOUR OF DEATH <u>7/8/72</u> <u>4:00 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1206</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>EM</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>7/28/10</u>		9. AGE (In years last birthday) <u>61</u>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITERMAN MAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Equitable Trust</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>UNKNOWN Wm A. Clayton</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN Mary Lydia</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. M. M. Quick - 2116 St. Paul St.</u>	
18. <u>5/19/31</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>SEPTICEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>C. O. L. D. And Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>6/10/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/10/72</u> to <u>7/8/72</u> , that (I) (we) last saw the deceased alive on <u>7/8/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Luis Sirotky</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/8/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Luis Sirotky</u>		23D. ADDRESS <u>UNION MEMORIAL Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-11-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Richmond, Virginia</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1972</u>		25B. NAME OF REGISTRAR <u>Audrey Whitton</u>	
25C. FUNERAL DIRECTOR <u>John C. Miller Inc-6415 Belair Rd.-21206</u>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

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72 06488		BALTIMORE CITY HEALTH DEPARTMENT		72 06488	
0-350		STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ODEN, EDWARD PEARCE		7-9-72 5:45 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
UNIVERSITY OF MARYLAND HOSPITAL 38				MD Frederick County 6011	
				C. CITY OR TOWN FREDERICK	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 905 N. MARKET ST	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
M	W			10/25/94	77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
PLUMBER		Plumbing		Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
MELVIN ODEN				MARY KANODE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		820-03-6142		Mrs. Allen Knill 27 East George Street Walkersville, Maryland	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLUS				45 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE R/O ACUTE MI DUE TO, OR AS A CONSEQUENCE OF:	
				(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF:	
				(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				STATUS Post Right Pylorohotomy 4 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
7/6/72		RIGHT KIDNEY STONE		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7-4-1972 to 7-9-1972 that (I) (we) last saw the deceased alive on 7-9-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Franklin Phiedma M.D.				7-9-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Franklin Phiedma M.D.				University Hospital, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/12/72		Mt. Olivet Cemetery	
				Frederick Frederick Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR, KENNEY, BASEFORD FUNERAL HOME	
JUL 12 1972				106 E. Church St. Frederick, Md. 21701	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8-500		72 06489		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06489	
BIRTH NO.		STATE OF MARYLAND-DHMH		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				DONAHUE, FRANK L. Sr.		7-10-72		3:22 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY					
SINAI HOSPITAL				M.D. BALTIMORE				5300	
				C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
				BALTIMORE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER					
				64 CEDAR HIGTS. CT. 21207					
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
M		W				2-3-95		77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
Exam.				Realestate				R.I.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?	
John Donahue				Mary Bartley				USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT	
yes				037 01 2442				Frank L Donahue Jr. 6728 Valley Creek Dr.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NOT A MEDICAL EXAMINER'S CASE. (This space is for use by a physician, e.g., for heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				CARDIAC ARREST				5 MIN.	
PRECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS PRECEDING THE CAUSE OF DEATH				Carcinoma of Lung SURGICAL PROCEDURE					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				TUMOR OF LUNG POSSIBLE CANCER				? MONTHS	
				(C) OLD MYOCARDIAL INFARCTION				?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)	
7-10-72				LUNG TUMOR				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
None				None				SINAI HOSPITAL None	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?	
None				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				DURING SURGERY None	
22. I certify that (this hospital) attended the deceased from 7-10-72 to 7-10-72 that (we) last saw the deceased alive on 7-10-72 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Ronald P. Byank, M.D.				7-10-72					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
R.P. BYANK, M.D.				SINAI HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
burial		7-13-72		Woodlawn Cemetery		Woodlawn, Balto., Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 13 1972		Andrew Johnston		John I. Stansbury		6411 Windsor Mill Rd.			

Handwritten notes at the top of the page, including "1000" and "10000".

Handwritten notes in the middle section, including "10000" and "1000".



Handwritten notes at the bottom of the page, including "1000" and "10000".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 4-400		72 06490		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 06490	
1. NAME OF DECEASED (Type or Print) Hull James					2. DATE AND HOUR OF DEATH July 7 1972 315 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL BALTIMORE MD.					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY SPRING GRAVE STATE HOSPITAL 5300				
					C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER				
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-4-92	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?			10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?			16. SOCIAL SECURITY NO. 579-52-6109		17. INFORMANT ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 0381914185X CAUSE OF DEATH (A) IMMEDIATE CAUSE SEP TILEMIA DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CANCER PROSTATE									
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/9 19 72 to 7/7 19 72 that (I) (we) last saw the deceased alive on 7/7/72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Walt Whitman					23B. DATE SIGNED 7/7/72			23C. PHYSICIAN'S NAME (Type) Walt Whitman	
23D. ADDRESS UNIVERSITY HOSPITAL BALTIMORE MD									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-11-72		24C. NAME OF CEMETERY or CREMATORY Lincoln Mem.		24D. LOCATION (City, town, or county) (State) Suitland MD			
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1972			25B. NAME OF REGISTRAR Sidney Winston			25C. FUNERAL DIRECTOR ADDRESS H.S. Washington & Sons 4825 Dean Ave. N.E.			

5/21/72

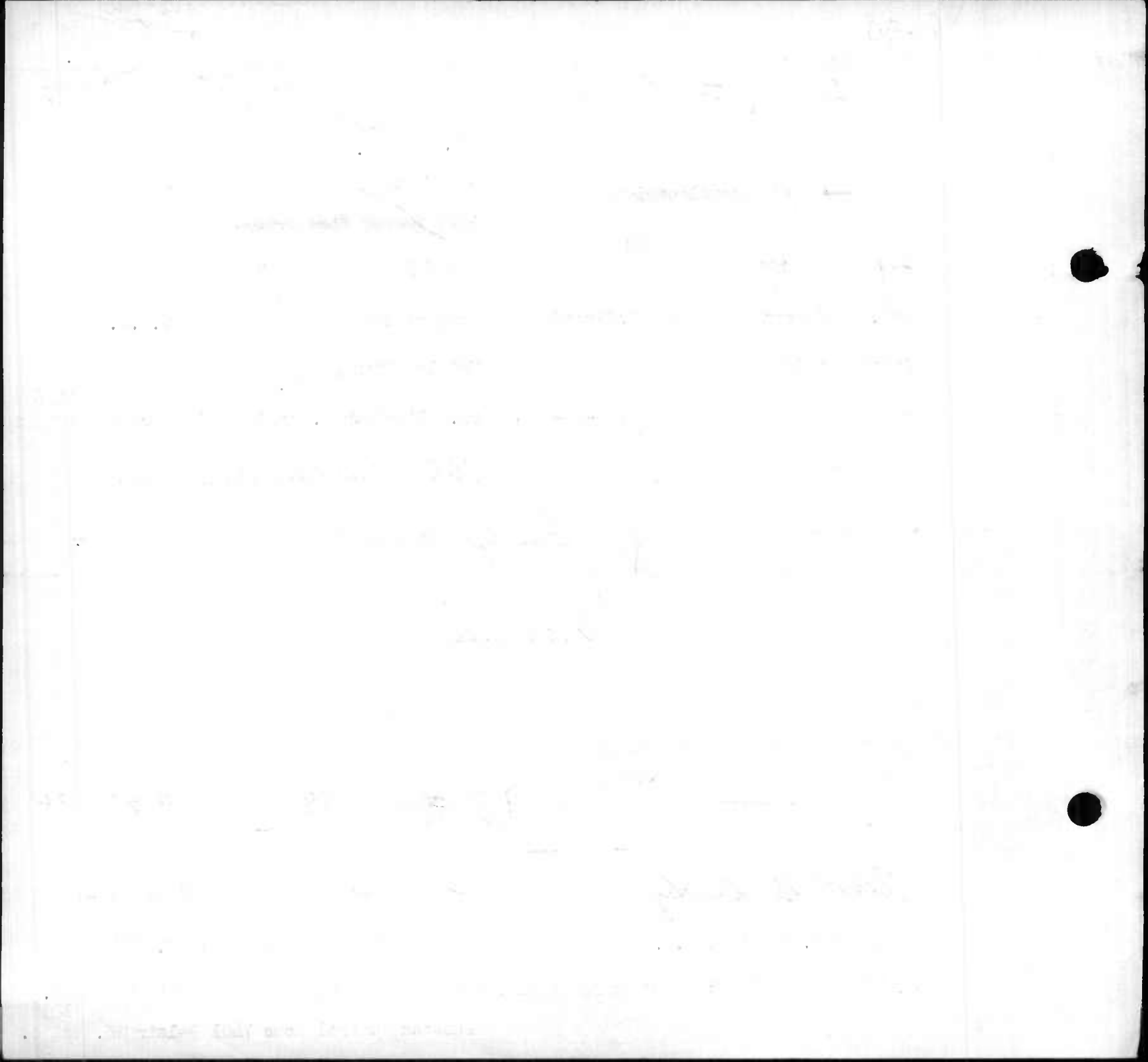
unable to obtain previous address.

J

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

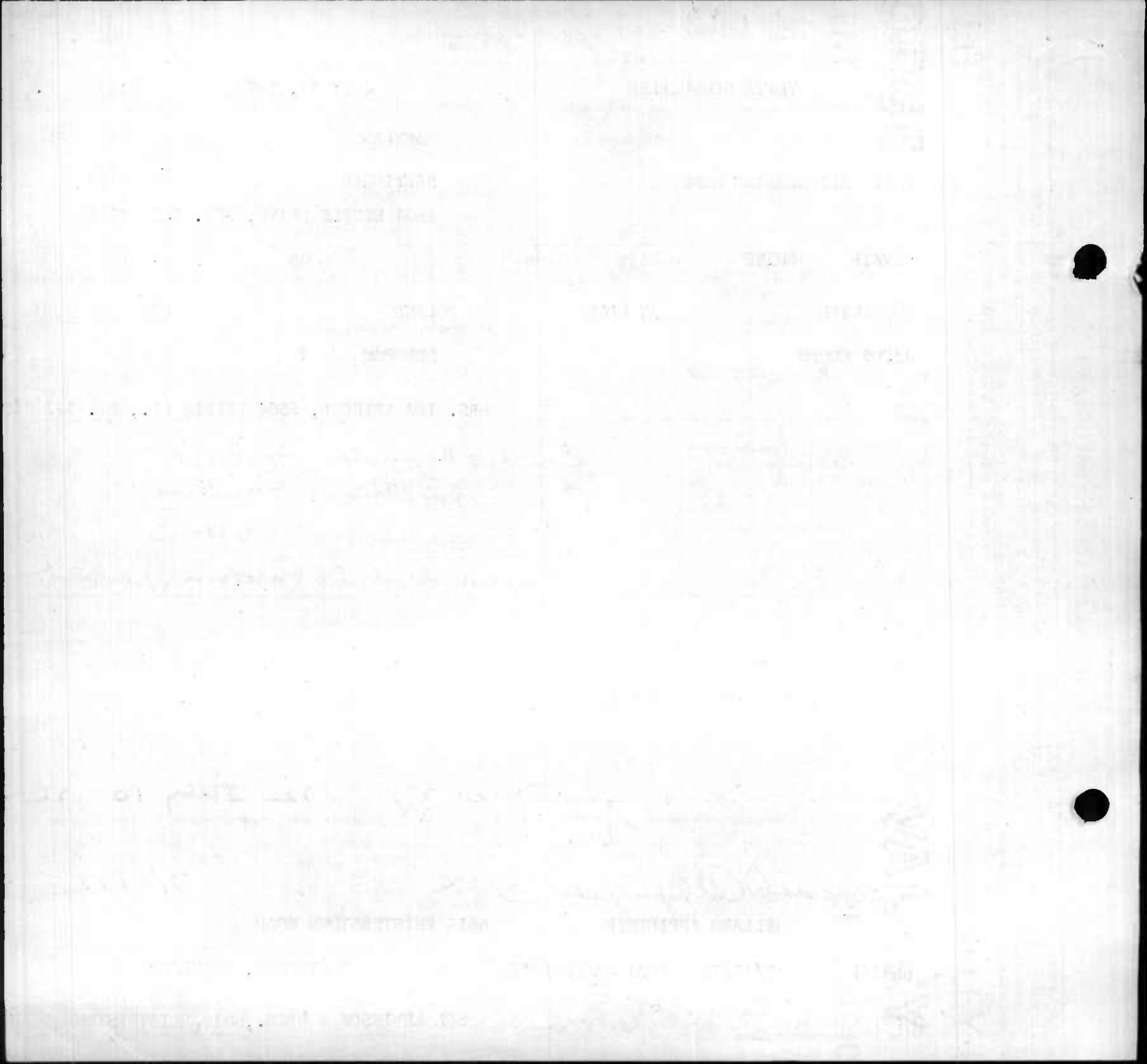
B-360 72 06491		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 06491	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) LEONARD J. BOODRY			2. DATE AND HOUR OF DEATH 7/11/72 7:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 The Gould Convalesarium			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Md. B. COUNTY 2631 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4427 Forest View Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/6/84	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Conductor		10B. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) Connecticut	
13. FATHER'S NAME James Boodry			14. MOTHER'S MAIDEN NAME Urilla Knox		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-07-9427		17. INFORMANT Mrs. Elizabeth C. Boodry	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/12/31 - 250.9 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Artiosclerosis Nerv. System (B) Gravely Artiosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/10/69 to 7/4/72 that (I) (we) last saw the deceased alive on 7/8/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley			23B. DATE SIGNED 7/4/72		23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/14/72		
24C. NAME OF CEMETERY or CREMATORY Garden Of Faith Cemetery			24D. LOCATION Overlea Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1972			25B. NAME OF REGISTRAR Lidney Weston		
25C. FUNERAL DIRECTOR Lassahn Funeral Home			ADDRESS 7401 Belair Rd. Balto.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

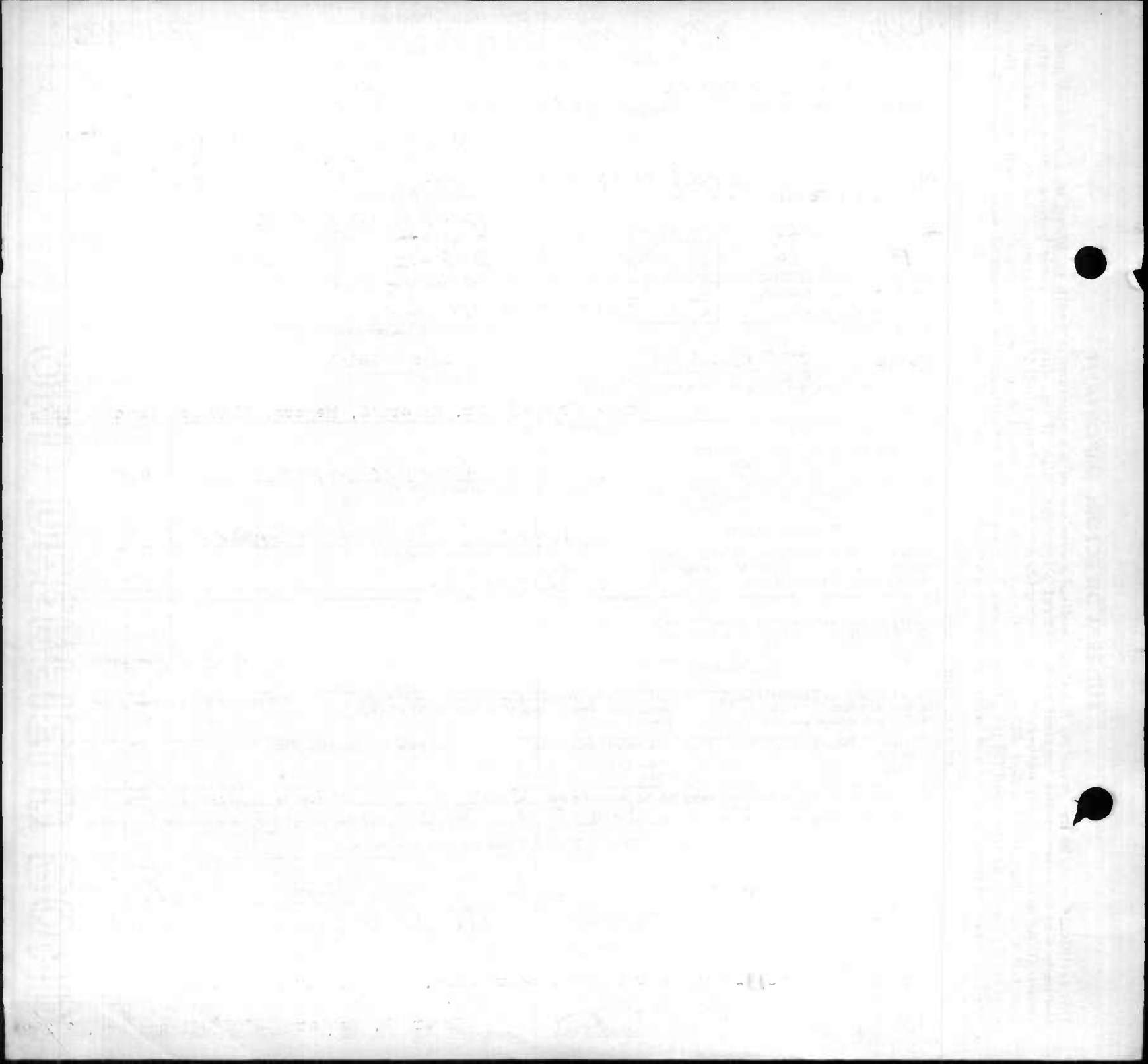
<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. <u>72 06492</u></p>	
<p><u>S-524</u> <u>72 06492</u></p> <p>BIRTH NO. <u>STATE OF MARYLAND-DEME</u></p>		<p>2. DATE AND HOUR OF DEATH</p> <p><u>JULY 10, 1972</u> <u>5:25</u> P. M.</p>	
<p>1. NAME OF DECEASED (Type or Print)</p> <p>YETTA SCHMUCKLER</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>MARYLAND</u> B. COUNTY <u>2831</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><u>PALL MALL NURSING HOME</u></p>		<p>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>6504 EBERLE DRIVE, APT. 102 #21215</u></p>	
<p>5. SEX <u>FEMALE</u></p>	<p>6. RACE <u>WHITE</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>90</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>HOUSEWIFE</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u></p>	<p>11. BIRTHPLACE (State or foreign country) <u>POLAND</u></p>
<p>13. FATHER'S NAME <u>JACOB COHEN</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>DEVORAH ?</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>NO</u></p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT ADDRESS</p> <p><u>MRS. IDA KRIEGER, 6504 EBERLE DR., APT. 102 #15</u></p>			
<p>18. <u>4/10/91</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <u>Cardio Respiratory Failure</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF <u>Congestive Heart Failure</u></p> <p>(B) <u>Arteriosclerotic CVD</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF <u>Myocardial Infarction, recent</u></p> <p>(C)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION <u>7/11/72</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <input type="checkbox"/></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <u>Mar 27</u> 19 <u>72</u> <u>July 10</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>July 10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>Willard Applefeld</u></p>		<p>23B. DATE SIGNED <u>7/11/72</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>WILLARD APPLEFELD</u></p>		<p>23D. ADDRESS <u>6615 REISTERSTOWN ROAD</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>24B. DATE <u>7/11/72</u></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <u>BNAI JACOB LODGE</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>Lidney Whitson</u></p>	
<p>25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS.</u></p>		<p>ADDRESS <u>6010 REISTERSTOWN ROAD</u></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 06493</u>	
M-620 72 06493		CERTIFICATE OF DEATH			
BIRTH NO. <u>72 06493</u>		STATE OF MARYLAND - DEMO			
1. NAME OF DECEASED (Type or Print) <u>Edna E. Meyers</u>		2. DATE AND HOUR OF DEATH <u>July 8, 1972</u> <u>3:40 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> <u>48</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1227 Linden Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-12</u>	9. AGE (in years last birthday) <u>60</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>supervisor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>J. H. Filbee + Inc</u>		11. BIRTHPLACE (State or foreign country) <u>N. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S</u>		13. FATHER'S NAME <u>Jesse Harden</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Welsh</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unkn</u>			
16. SOCIAL SECURITY NO. <u>056 03 0163</u>		17. INFORMANT <u>Mr. Robert S. Meyers, 7210 Oak Haven Circle</u>			
18. <u>250.91</u>		ADDRESS <u>21207</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <u>Arterial Insuff. - Stroke</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>Diabetes</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>June 9</u> 19 <u>72</u> to <u>July 8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>July 8</u> 19 <u>72</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Eugene J. Strasser M.D.</u>				23B. DATE SIGNED <u>7/8/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Eugene J. Strasser</u>				23D. ADDRESS <u>Maryland General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-13-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Fairmount Cemetery Asso.</u>	
24D. LOCATION <u>Denver, Colorado</u>		24E. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1972</u>		25B. NAME OF REGISTRAR <u>A. J. Johnson</u>		25C. ADDRESS	



H-620

72 06494

BALTIMORE CITY HEALTH DEPARTMENT

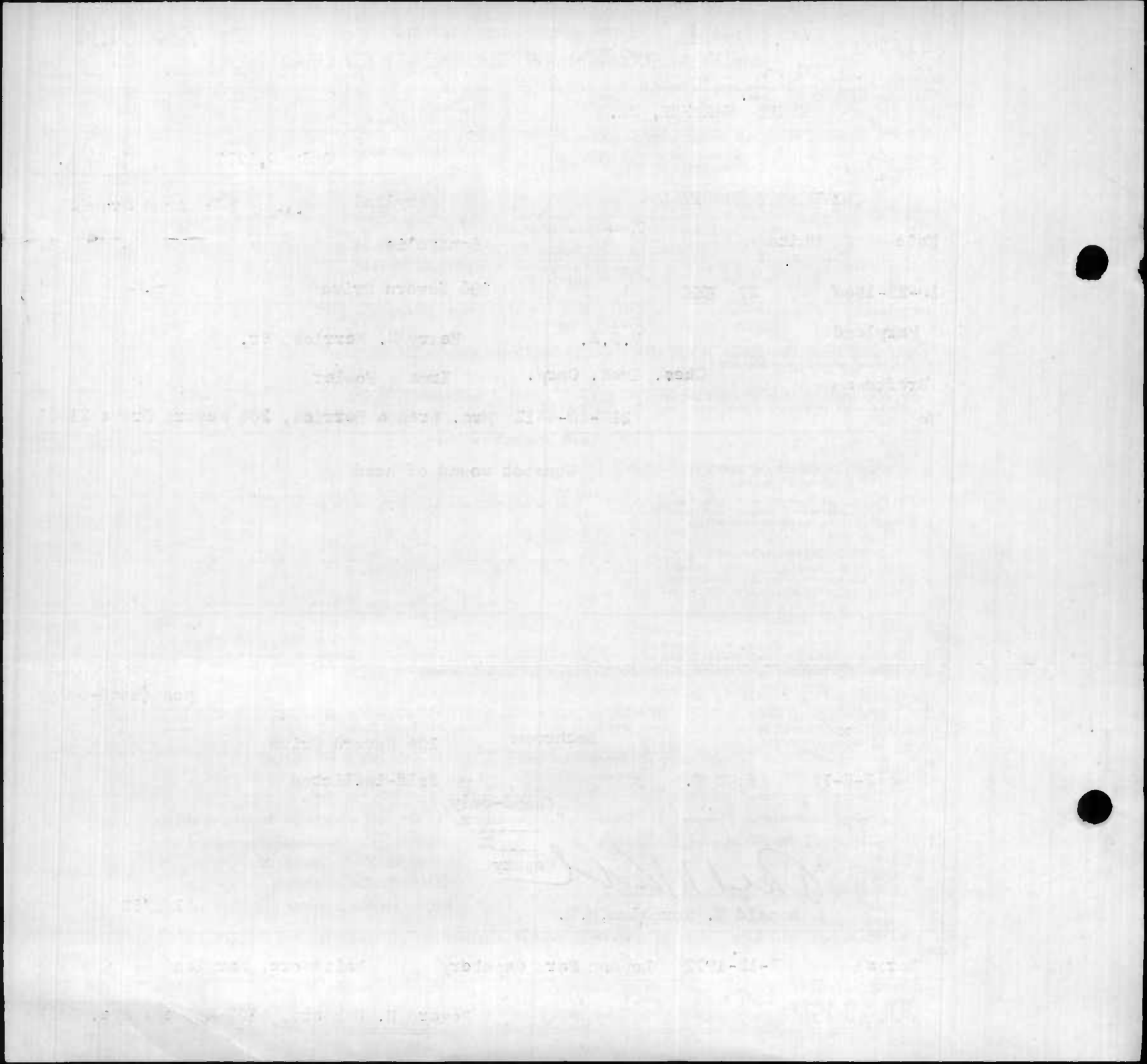
72 06494

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. STATE OF MARYLAND-DHMH

REG. NO.

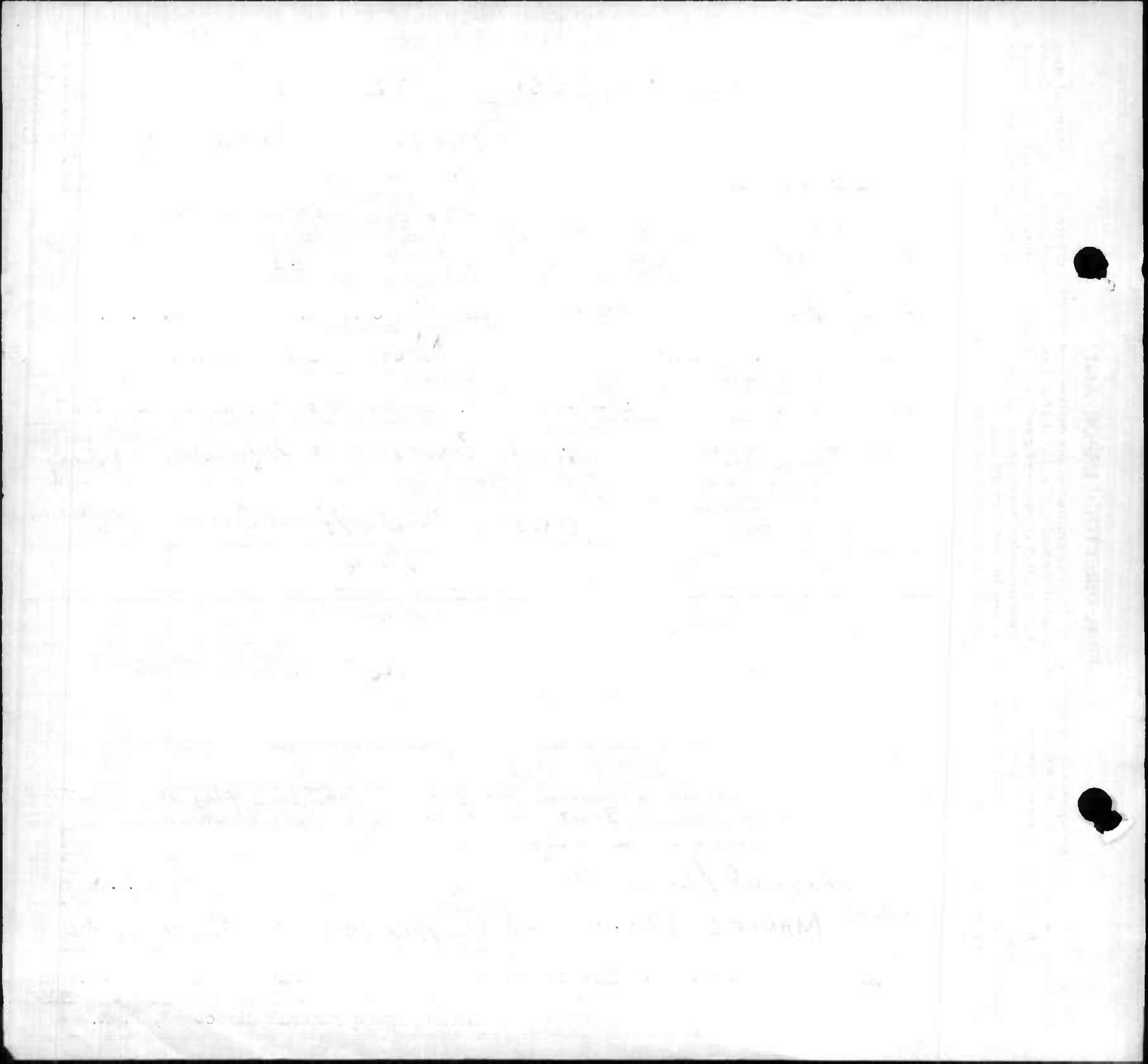
1. NAME OF DECEASED (Type or Print) HENRY HERRICK, JR.				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour July 8, 1972 1:54 A. M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10-25-1944				10. AGE (In years last birthday) 27 XXX		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Henry E. Herrick, Sr.		14. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel	
15. MOTHER'S MAIDEN NAME Irma Fowler				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-40-4412	
18. INFORMANT Mrs. Brenda Herrick, 204 Severn Drive 21401				19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bathroom		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 204 Severn Drive	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-7-72 6:00 P.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Self-inflicted	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/8/72				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7-12-1972				24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1972				25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 06495	
BIRTH NO. 72 06495				REG. NO. 72 06495	
STATE OF MARYLAND - DEPT. OF HEALTH				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ETHEL M. MYERS			JULY 10 / 72 945 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital			A. STATE & COUNTY 4918 REISTERSTOWN RD BALTO MD.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		
42			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX F			6. RACE W		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 7/1/90		
9. AGE (in years last birthday) 82			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		
11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Samuel A. Naylor			14. MOTHER'S MAIDEN NAME Alice Martin Shultz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None			16. SOCIAL SECURITY NO. 216-07-6916		
17. INFORMANT Mr. Raymond Myers 6705 Carol Road 21207			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ATHEROSCLEROTIC HEART DISEASE 5 years		
(B) DUE TO, OR AS A CONSEQUENCE OF: none			(C) DUE TO, OR AS A CONSEQUENCE OF: none		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). none					
21A. DATE OF OPERATION			21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Aug 10 1971 to July 10 1972 that (I) (we) last saw the deceased alive on JULY 10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel Levin M.D.			23B. DATE SIGNED 7/10/72		
23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN			23D. ADDRESS MD 6101 PARK HTS AVE BALTO - 15 MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/13/1972		
24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			24D. LOCATION (City, town, or county) (State) Woodlawn Baltimore Co., Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1972			25B. NAME OF REGISTRAR Loring Byers		
25C. FUNERAL DIRECTOR 8728 Liberty Road ADDRESS 21133			Loring Byers Funeral Directors, P. A.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>8-600 72 06496</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 06496</p>	
<p>BIRTH NO. STATE OF MARYLAND-DHMH</p> <p>1. NAME OF DECEASED (Type or Print) CHARLES A. SCHIER</p>		<p>2. DATE AND HOUR OF DEATH JULY 10 1972 7:35 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)</p> <p>A. STATE MD. B. COUNTY 2403</p>	
<p>5. SEX M 6. RACE W</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH 7-17-19</p>		<p>9. AGE (In years last birthday) 85</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Own.</p>	
<p>11. BIRTHPLACE (State or foreign country) MD.</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME Geo 192</p>		<p>14. MOTHER'S MAIDEN NAME Katherine Ulrich</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 2-9-26-4508</p>	
<p>17. INFORMANT Family - Jane</p>		<p>ADDRESS</p>	
<p>18. 25071 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>(A) IMMEDIATE CAUSE CEREBRAL VASCULAR ACCIDENT 1 MONTH</p> <p>(B) ARTERIOSCLEROTIC & HYPERTENSIVE CARDIOVASCULAR DISEASE 20 YRS.</p> <p>(C) DIABETES MELLITUS 50 YRS.</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from JUNE 11 1972 to JULY 10 1972 that (I) (we) last saw the deceased alive on JULY 10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Robert J. Bauer, M.D.</p>		<p>23B. DATE SIGNED 7/10/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) ROBERT J. BAUER, M.D.</p>		<p>23D. ADDRESS SOUTH BALT. GENERAL HOSPITAL 3601 SOUTH MANEY ST. BALT., MD.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) B</p>		<p>24B. DATE 7-13-72</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY LONDON PARK</p>		<p>24D. LOCATION (City, town, or county) (State) BALTIMORE</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 13 1972</p>		<p>25B. NAME OF REGISTRAR Frederick Johnson</p>	
<p>25C. FUNERAL DIRECTOR McCully - 130 E. Pratt St.</p>		<p>ADDRESS</p>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
<div style="display: flex; justify-content: space-between;"> H-532 72 06497 </div>				72 06497
CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
HEINTZ, RAE MARIE		JULY 9, 1972		5:05P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MARYLAND 21229		A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 404 SMALLWOOD ST.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05 22 17	9. AGE (In years last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JOHN MILLER		14. MOTHER'S MAIDEN NAME FRANCES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-0444		17. INFORMANT STAGNES RECORDS - WILKENS & CATON AVES.
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF: (B) CHRONIC CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE CHRONIC BRAIN SYNDROME		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from JUNE 28, 1972 to JULY 9, 1972, that (X) (we) last saw the deceased alive on JULY 9, 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE BENAVIDES		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) BENAVIDES, VICTOR M.D.		23D. ADDRESS WILKENS & CATON AVE. BALTO. MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/72		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue 21228

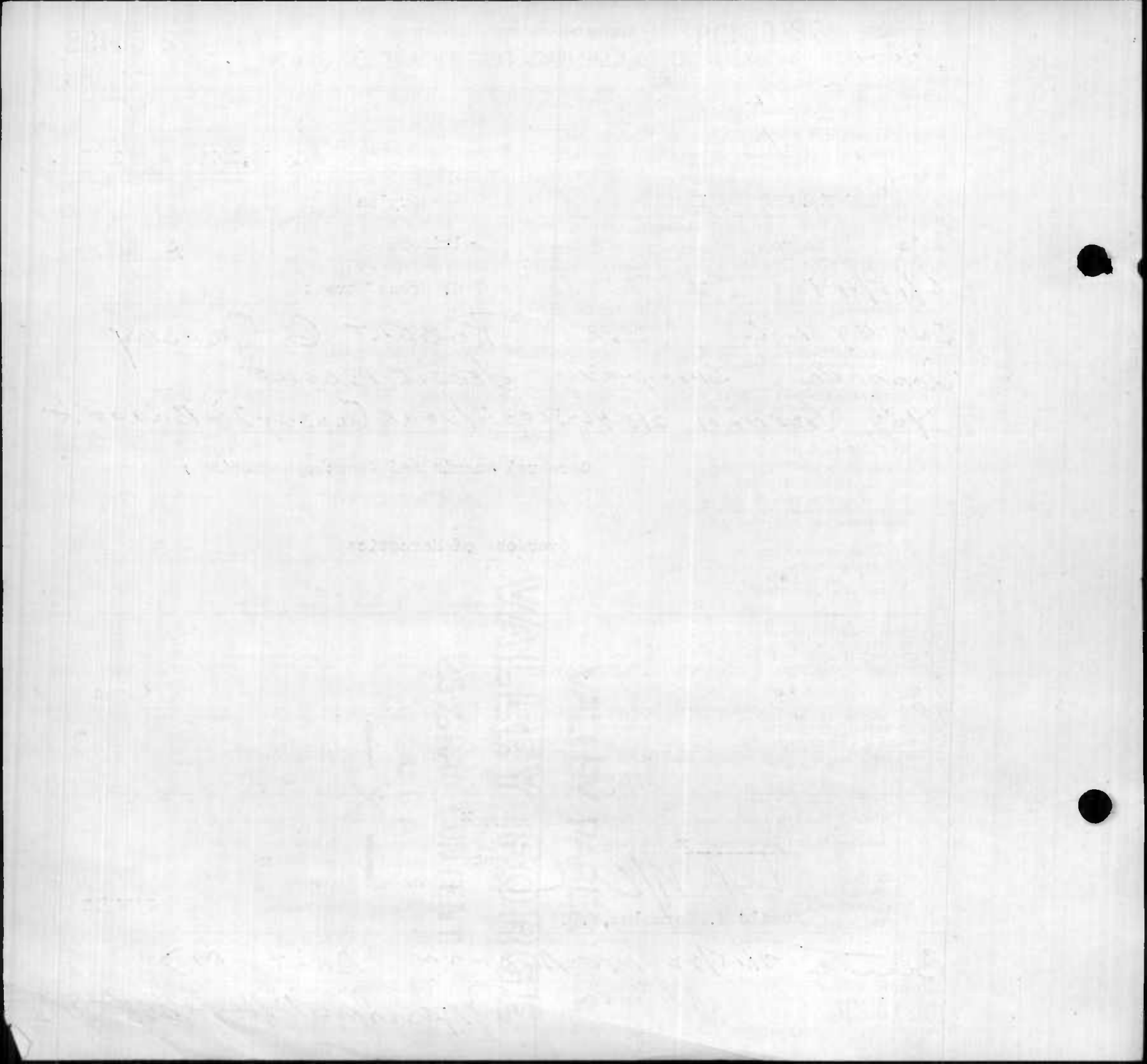
ST. ADAMS HOSPITAL
WILKINS & CATON AVE.
BALTIMORE, MARYLAND 21229

BALTIMORE
404 SMALLWOOD ST.

U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

WILKINS & CATON AVE.
BALTIMORE, MARYLAND 21229

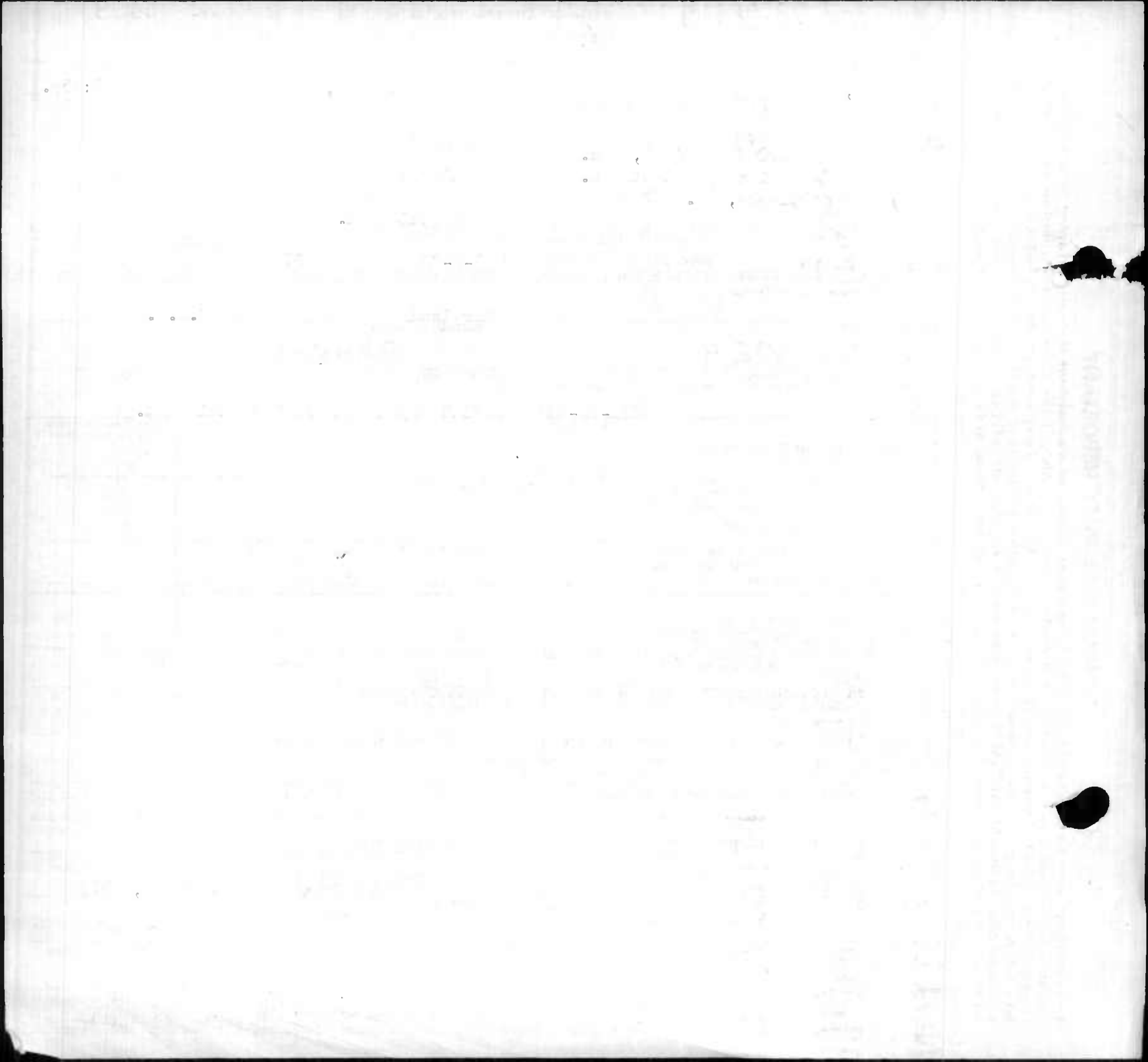
72 06498		BALTIMORE CITY HEALTH DEPARTMENT		72 06498	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. STATE OF MARYLAND-DEME					
1. NAME OF DECEASED (Type or Print) ROBERT CROSBY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour July 10, 1972 3:07 P. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1901	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 6/15/44	10. AGE (in years last birthday) 28	11. BIRTHPLACE (State or foreign country) SNEIRY N.C.	12. CITIZEN OF WHAT COUNTRY? USA		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		14B. KIND OF BUSINESS OR INDUSTRY SHIPYARD		15. MOTHER'S MAIDEN NAME JESSIE MOORE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES VIETNAM 2/5-4/6/68		17. SOCIAL SECURITY NO. 215-46-0000		18. INFORMANT ADDRESS FLORA CROSBY 7 N. Bruce St	
19. 304.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Cerebral Anoxia and Bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Overdose of Narcotics (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 7/11/72					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/15/72		24C. NAME OF CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore MD		25A. DATE REC'D BY HEALTH DEPT. JUL 13 1972		25B. NAME OF REGISTRAR Audrey Johnson	
25C. FUNERAL DIRECTOR Marshall P. Ray		25D. ADDRESS 2501 29th St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> D-000 72 06499 STATE OF MARYLAND-DHMH </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 72 06499	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Day, Frank		July 11, 1972 7:05pm	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1403	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1909 Etting St.	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-35
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 37
		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Day		14. MOTHER'S MAIDEN NAME Johnson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-30-4541	17. INFORMANT Judith Day (MOTHER) 1909 Etting St.
18. 577.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Hemorrhagic Pancreatitis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Delirium Tremens Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/10/72 to 7/11/72 that (I) (we) last saw the deceased alive on 7:05pm 7/11/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Benito Kong Leng COMD			23B. DATE SIGNED July 11, 1972
23C. PHYSICIAN'S NAME (Type) BENITO KONG-LENG COMD		23D. ADDRESS PROVIDENT HOSPITAL, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-72	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1972		25B. NAME OF REGISTRAR Frederick H. ...	
25C. FUNERAL DIRECTOR William ...		ADDRESS 2706 ...	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>H-45272-09931</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 06500</u>	
1. NAME OF DECEASED (Type or Print) <u>HALLUMS, BABY GIRL</u>		2. DATE AND HOUR OF DEATH <u>7-1-72 11:29 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1703</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BALTIMORE CITY HOSPITALS</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4940 Eastern Ave. Baltimore, Md. 21224		E. STREET AND NUMBER <u>700 BRUNE STREET</u>			
5. SEX <u>Female</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-72</u>	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Beneita</u>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>BCH. Records: 4940 Eastern Ave. Baltimore, Md. 21224</u>	
18. <u>776.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Cardio RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <u>PREMATURITY AND RESPIRATORY</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>DISTRESS SYNDROME</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-1-1972</u> to <u>7-1-1972</u> and that (I) (we) last saw the deceased alive on <u>7-1-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. H. P. Kulasinghe</u>				23B. DATE SIGNED <u>7-1-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. H. P. KULASINGHE</u>				23D. ADDRESS <u>BALTIMORE CITY HOSPITAL, 4940 Eastern Ave. Baltimore, Md. 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremations</u>		24B. DATE <u>7-5-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore City Hospitals</u>	
				24D. LOCATION (City, town, or county) (State) <u>4940 Eastern Avenue Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1972</u>		25B. NAME OF REGISTRAR <u>Dr. H. P. Kulasinghe</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	

